2021 Proceedings of the National Association of Insurance Commissioners

2021 Virtual Spring National Meeting
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Concerning Business Conducted
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CERTIFICATE OF INCORPORATION OF
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
a Nonstock Corporation

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

II. Duration
The period of duration of the NAIC is perpetual.

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

IV. Authority to Issue Stock
The NAIC shall have no authority to issue capital stock.

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

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

(a) Protect the public interest, promote competitive markets and facilitate the fair and equitable treatment of insurance consumers;
(b) Promote, in the public interest, the reliability, solvency and financial solidity of insurance institutions; and
(c) Support and improve state regulation of insurance.

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

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

1. The Corporation shall not engage in any act of self-dealing as defined in section 4941(d) of the Code.
2. The Corporations shall make distributions for each taxable year at such time and in such manner so as not to become subject to the tax on undistributed income imposed by section 4942 of the Code.
3. The Corporation shall not retain any excess business holdings as defined in section 4943(c) of the Code.
4. The Corporation shall not make any investments in such manner as to subject it to tax under section 4944 of the Code.
5. The Corporation shall not make any taxable expenditures as defined in section 4945(d) of the Code.
VIII. Membership

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

IX. Activities

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

X. Powers

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

XI. Immunity

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

XII. Exculpation and Indemnification

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

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

XIII. Dissolution

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

XIV. Bylaws

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

XV. Amendments

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

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

/signature/
Catherine J. Weatherford, Incorporator

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

ARTICLE I Name, Organization and Location

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

ARTICLE II Membership

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

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

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

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

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

ARTICLE III Officers

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

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

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

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

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

**ARTICLE IV Executive Committee**

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) NAIC OFFICES

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

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

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

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

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

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

The Internal Administration (EX1) Subcommittee shall:

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

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

4. Audit Committee

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

ARTICLE V Zones

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

ARTICLE VI Standing Committees and Task Forces

1. General

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

2. Specific Duties

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

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

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

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

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

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

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

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

3. Task Forces

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

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

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

1. Regular Meetings.

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

2. Special Meetings.

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

3. Waiver of Notice; Postponement.

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

4. Quorum.

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

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

ARTICLE VIII Elections

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

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

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

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

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

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

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

   (b) President-Elect.

   (c) Vice President.

   (d) Secretary-Treasurer.

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

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

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

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

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

**ARTICLE IX Proxies; Waiver of Notice**

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

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

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

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

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

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

ARTICLE XI Amendments

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Plenary

Executive Committee

(Ex1)
Subcommittee

Internal Administration

Information Systems Task Force

(A) Committee

Life Insurance and Annuities

Life Actuarial Task Force

(C) Committee

Property and Casualty Insurance

Casualty Actuarial and Statistical Task Force
Surplus Lines Task Force
Title Insurance Task Force
Workers’ Compensation Task Force

(E) Committee

Financial Condition

Accounting Practices and Procedures Task Force
Capital Adequacy Task Force
Examination Oversight Task Force
Financial Stability Task Force
Receivership and Insolvency Task Force
Reinsurance Task Force
Risk Retention Group Task Force
Valuation of Securities Task Force

(B) Committee

Health Insurance and Managed Care

Health Actuarial Task Force
Regulatory Framework Task Force
Senior Issues Task Force

(D) Committee

Market Regulation and Consumer Affairs

Antifraud Task Force
Market Information Systems Task Force
Producer Licensing Task Force

(F) Committee

Financial Regulation Standards and Accreditation

(G) Committee

International Insurance Relations

NAIC/Consumer Liaison Committee

NAIC/American Indian and Alaska Native Liaison Committee

Updated January 25, 2021
# APPOINTED and DISBANDED GROUPS

## Current and Previous Year

### APPOINTED SINCE JANUARY 2021

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<th>Group Name and Description</th>
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<tr>
<td>Long-Term Care Insurance Restructuring (E) Subgroup</td>
<td>04/07/2021</td>
<td>Dan Daveline</td>
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<td>Receiver’s Handbook (E) Subgroup</td>
<td>04/13/2021</td>
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<td>Tim Nauheimer</td>
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<td>Liquidity Assessment (E) Subgroup (f.k.a. Liquidity Assessment (EX) Subgroup)</td>
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<td>Mutual Recognition of Jurisdictions (E) Working Group (f.k.a. Qualified Jurisdiction (E) Working Group)</td>
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### DISBANDED SINCE JANUARY 2021

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<td>Biographical Third-Party Review (E) Subgroup</td>
<td>04/13/2021</td>
<td>Crystal Brown</td>
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<td>Retirement Security (A) Working Group</td>
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*Updated April 15, 2021*
# 2021 Members by Zone

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<thead>
<tr>
<th>Northeast Zone</th>
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<tbody>
<tr>
<td>Jessica K. Altman, Chair</td>
<td>Jim L. Ridling, Chair</td>
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<td>Gary D. Anderson, Vice Chair</td>
<td>Mike Chaney, Vice Chair</td>
</tr>
<tr>
<td>Kathleen A. Birrane, Secretary</td>
<td>James J. Donelon, Secretary</td>
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<tr>
<td>Glen Mulready, Vice Chair</td>
<td>Michael Conway, Vice Chair</td>
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<td>Dana Popish Severinghaus</td>
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*Updated April 5, 2021*
# 2021 EXECUTIVE (EX) COMMITTEE

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<tr>
<th>Position</th>
<th>Name</th>
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<tr>
<td>President</td>
<td>David Altmaier</td>
<td>Florida</td>
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<tr>
<td>President-Elect</td>
<td>Dean L. Cameron</td>
<td>Idaho</td>
</tr>
<tr>
<td>Vice President</td>
<td>Chlora Lindley-Myers</td>
<td>Missouri</td>
</tr>
<tr>
<td>Secretary-Treasurer</td>
<td>Andrew N. Mais</td>
<td>Connecticut</td>
</tr>
<tr>
<td>Most Recent Past President</td>
<td>Raymond G. Farmer</td>
<td>South Carolina</td>
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**Northeast Zone**

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<thead>
<tr>
<th>Role</th>
<th>Name</th>
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<tbody>
<tr>
<td>Chair</td>
<td>Jessica K. Altman</td>
<td>Pennsylvania</td>
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<tr>
<td>Vice Chair</td>
<td>Gary D. Anderson</td>
<td>Massachusetts</td>
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<tr>
<td>Secretary</td>
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**Southeast Zone**

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<td>Chair</td>
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<td>Secretary</td>
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**Midwest Zone**

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<tr>
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<td>Larry D. Deiter</td>
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<td>Vice Chair</td>
<td>Glen Mulready</td>
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<td>Secretary</td>
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**Western Zone**

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<td>Chair</td>
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<td>Vice Chair</td>
<td>Michael Conway</td>
<td>Colorado</td>
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<tr>
<td>Secretary</td>
<td>Andrew R. Stolfi</td>
<td>Oregon</td>
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NAIC Support Staff: Andrew J. Beal/Kay Noonan

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

Ricardo Lara, Co-Chair
Raymond G. Farmer, Co-Chair
Colin M. Hayashida, Co-Vice Chair
James J. Donelon, Co-Vice Chair
Kathleen A. Birrane, Co-Vice Chair
Bruce R. Ramge, Co-Vice Chair
Andrew R. Stolfi, Co-Vice Chair
Jim L. Ridling
Lori K. Wing-Heier
Michael Conway
Andrew N. Mais
Trinidad Navarro
Karima M. Woods
David Altmaier
Stephen W. Robertson
Eric A. Cioppa
Gary D. Anderson
Anita G. Fox
Grace Arnold
Barbara D. Richardson
Marlene Caride
Russell Toal
Linda A. Lacewell
Jon Godfread
Jessica K. Altman
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NAIC Support Staff: Jolie H. Matthews/Joe Touschner
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<tr>
<td>Marlene Caride, Chair</td>
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## Cannabis Insurance (C) Working Group

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<td>Mike Arendall</td>
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<td>Monica Macaluso</td>
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<td>Robert Ballard</td>
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<td>Daniel Morris</td>
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NAIC Support Staff: Jacob Steilen/Bailey Henning

FINANCIAL STABILITY (E) TASK FORCE
of the Financial Condition (E) Committee

Marlene Caride, Chair
Eric A. Cioppa, Vice Chair
Alan McClain
Ricardo Lara
Andrew N. Mais
Karima M. Woods
David Altmaier
Doug Ommen
Kathleen A. Birrane
Gary D. Anderson
Chlora Lindley-Myers
Bruce R. Ramge
Linda A. Lacewell
Andrew R. Stolfi
Jessica K. Altman
Raymond G. Farmer
Carter Lawrence
Doug Slape
Scott A. White

New Jersey
Maine
Arkansas
California
Connecticut
District of Columbia
Florida
Iowa
Maryland
Massachusetts
Missouri
Nebraska
New York
Oregon
Pennsylvania
South Carolina
Tennessee
Texas
Virginia

NAIC Support Staff: Tim Nauheimer/Todd Sells
FINANCIAL STABILITY (E) TASK FORCE (Continued)

Liquidity Assessment (E) Subgroup
of the Financial Condition (E) Committee

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Kathy Belfi/John Loughran
Philip Barlow
Ray Spudeck
Vincent Tsang
Carrie Mears
Fred Andersen
John Rehagen
Mike Boerner
Nebraska
Connecticut
District of Columbia
Florida
Illinois
Iowa
Minnesota
Missouri
Texas

NAIC Support Staff: Tim Nauheimer/Todd Sells

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE
of the Financial Condition (E) Committee

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Peni Itula Sapini Teo
Evan G. Daniels
Michael Conway
Andrew N. Mais
David Altmayer
Colin M. Hayashida
Dana Popish Severinghaus
Doug Ommen
Vicki Schmidt
Sharon P. Clark
Eric A. Cioppa
Gary D. Anderson
Anita G. Fox
Chlora Lindley-Myers
Troy Downing
Edward M. Deleon Guerrero
Bruce R. Ramge
Marlene Caride
Russel Toal
Mike Causey
Glen Mulready
Jessica K. Altman
Elizabeth Kelleher Dwyer
Raymond G. Farmer
Jonathan T. Pike
Texas
Louisiana
American Samoa
Arizona
Colorado
Connecticut
Florida
Hawaii
Illinois
Iowa
Kansas
Kentucky
Maine
Massachusetts
Michigan
Missouri
Montana
N. Mariana Islands
Nebraska
New Jersey
New Mexico
North Carolina
Oklahoma
Pennsylvania
Rhode Island
South Carolina
Utah

NAIC Support Staff: Jane Koenigsman
RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE (Continued)

Receiver’s Handbook (E) Working Group
of the Receivership and Insolvency (E) Task Force

(Pending), Chair
(Pending), Vice Chair
Jared Kosky Connecticut
Toma Wilkerson Florida
Kevin Baldwin Illinois
James Gerber Michigan
Leatrice Geckler New Mexico
Donna Wilson Oklahoma
Laura Lyon Slaymaker Pennsylvania

NAIC Support Staff: Sherry Flippo/Jane Koenigsman

Receivership Financial Analysis (E) Working Group
of the Receivership and Insolvency (E) Task Force

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Donna Wilson, Co-Chair Oklahoma
Joe Holloway California
Kevin Baldwin/Douglas Harrell Illinois
Kim Cross/Daniel Mathis Iowa
David Axinn New York
Laura Lyon Slaymaker Pennsylvania
James Kennedy Texas
Steve Drutz/Melanie Anderson Washington

NAIC Support Staff: Jane Koenigsman

Receivership Law (E) Working Group
of the Receivership and Insolvency (E) Task Force

Kevin Baldwin, Co-Chair Illinois
Laura Lyon Slaymaker, Co-Chair Pennsylvania
Steve Uhrynnowycz Arkansas
Joe Holloway/Jack Hom California
Rolf Kaumann Colorado
Jared Kosky Connecticut
Toma Wilkerson Florida
Kim Cross Iowa
Tom Travis Louisiana
Robert Wake Maine
Christopher Joyce Massachusetts
James Gerber Michigan
Shelley Forrest Missouri
Justin Schrader Nebraska
James Kennedy Texas
Melanie Anderson Washington

NAIC Support Staff: Jane Koenigsman
### REINSURANCE (E) TASK FORCE
of the Financial Condition (E) Committee

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<td>Raymond G. Farmer, Vice Chair</td>
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NAIC Support Staff: Jake Stultz/Dan Schelp
**REINSURANCE (E) TASK FORCE (Continued)**

Reinsurance Financial Analysis (E) Working Group  
_of the Reinsurance (E) Task Force_

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<td>Diana Sherman</td>
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<td>Roberto Paradis/Joan Riddell</td>
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<td>Amy Garcia</td>
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NAIC Support Staff: Andy Daleo/Dan Schelp

**RISK RETENTION GROUP (E) TASK FORCE**  
_of the Financial Condition (E) Committee_

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NAIC Support Staff: Becky Meyer/Sara Franson
VALUATION OF SECURITIES (E) TASK FORCE
of the Financial Condition (E) Committee

Dana Popish Severinghaus, Chair
Doug Ommen, Vice Chair
Lori K. Wing-Heier
Ricardo Lara
Andrew N. Mais
Trinidad Navarro
David Altmaier
Dean L. Cameron
Vicki Schmidt
James J. Donelon
Kathleen A. Birrane
Gary D. Anderson
Chlora Lindley-Myers
Bruce R. Ramge
Marlene Caride
Russell Toal
Linda A. Lacewell
Doug Slape
Jonathan T. Pike
Scott A. White
Mike Kreidler
Mark Afable

Illinois
Iowa
Alaska
California
Connecticut
Delaware
Florida
Idaho
Kansas
Louisiana
Maryland
Massachusetts
Missouri
Nebraska
New Jersey
New Mexico
New York
Texas
Utah
Virginia
Washington
Wisconsin

NAIC Support Staff: Charles A. Therriault
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<td>Andrew N. Mais</td>
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<tr>
<td>Jeff Rude</td>
<td>Wyoming</td>
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NAIC Support Staff: Becky Meyer/Sara Franson
INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

Gary D. Anderson, Chair  Massachusetts
Bruce R. Ramge, Vice Chair  Nebraska
Evan G. Daniels  Arizona
Andrew N. Mais  Connecticut
Karima M. Woods  District of Columbia
David Altmaier  Florida
Doug Ommen  Iowa
James J. Donelon  Louisiana
Kathleen A. Birrane  Maryland
Anita G. Fox  Michigan
Chlora Lindley-Myers  Missouri
Marlene Caride  New Jersey
Andrew R. Stolfi  Oregon
Jessica K. Altman  Pennsylvania
Raymond G. Farmer  South Carolina

NAIC Support Staff: Ryan Workman/Nikhail Nigam
<table>
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<th>NAIC/CONSUMER LIAISON COMMITTEE</th>
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<tr>
<td>Michael Conway, Chair</td>
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<tr>
<td>Andrew R. Stolfi, Vice Chair</td>
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<tr>
<td>Jim L. Ridling</td>
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<td>Mike Kreidler</td>
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<td>Mark Afable</td>
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NAIC Support Staff: Lois E. Alexander
NAIC/CONSUMER LIAISON COMMITTEE (Continued)

NAIC/American Indian and Alaska Native Liaison Committee
of the NAIC/Consumer Liaison Committee

<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>Lori K. Wing-Heier, Chair</td>
<td>Alaska</td>
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<tr>
<td>Jeff Rude, Vice Chair</td>
<td>Wyoming</td>
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<td>Michael Conway</td>
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<td>Washington</td>
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</tbody>
</table>

NAIC Support Staff: Lois E. Alexander
MEMBERS OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Alabama Commissioner
Jim L. Ridling Montgomery 36130

Alaska Director
Lori K. Wing-Heier Anchorage 99501

American Samoa Commissioner
Peni Itula Sapini Teo Pago Pago 96799

Arizona Director
Evan G. Daniels Phoenix 85018

Arkansas Commissioner
Alan McClain Little Rock 72202

California Commissioner
Ricardo Lara Oakland 94612

Colorado Commissioner
Michael Conway Denver 80202

Connecticut Commissioner
Andrew N. Mais Hartford 06103

Delaware Commissioner
Trinidad Navarro Dover 19904

District of Columbia Commissioner
Karima M. Woods Washington 20002

Florida Commissioner
David Altmaier Tallahassee 32399

Georgia Commissioner
John F. King Atlanta 30334

 Guam Commissioner
Michelle B. Santos Barrigada 96913

Hawaii Commissioner
Colin M. Hayashida Honolulu 96813

Idaho Director
Dean L. Cameron Boise 83720

Illinois Acting Director
Dana Popish Severinghaus Springfield 62767

Indiana Commissioner
Stephen W. Robertson Indianapolis 46204

Iowa Commissioner
Doug Ommen Des Moines 50319

Kansas Commissioner
Vicki Schmidt Topeka 66612

Kentucky Commissioner
Sharon P. Clark Frankfort 40601

Louisiana Commissioner
James J. Donelon Baton Rouge 70802

Maine Superintendent
Eric A. Cioppa Augusta 04333

Maryland Commissioner
Kathleen A. Birrane Baltimore 21202

Massachusetts Commissioner
Gary D. Anderson Boston 02118

Michigan Director
Anita G. Fox Lansing 48933

Minnesota Temporary Commissioner
Grace Arnold St. Paul 55101

Mississippi Commissioner
Mike Chaney Jackson 39201

Missouri Director
Chlora Lindley-Myers Jefferson City 65101

Montana Commissioner/State Auditor
Troy Downing Helena 59601

Nebraska Director
Bruce R. Ramge Lincoln 68501

Nevada Commissioner
Barbara D. Richardson Carson City 89706

New Hampshire Commissioner
Chris Nicolopolous Concord 03301

New Jersey Commissioner
Marlene Caride Trenton 08625

New Mexico Superintendent
Russell Toal Santa Fe 87501

New York Superintendent
Linda A. Lacewell New York 10004

North Carolina Commissioner
Mike Causey Raleigh 27603

North Dakota Commissioner
Jon Godfread Bismarck 58505

N. Mariana Islands Acting Secretary of Commerce
Edward M. Deleon Guerrero Saipan 96950

Ohio Director
Judith L. French Columbus 43215

Oklahoma Commissioner
Glen Mulready Oklahoma City 73112

Oregon Insurance Commissioner
Andrew R. Stolfi Salem 97301

Pennsylvania Commissioner
Jessica K. Altman Harrisburg 17120

Puerto Rico Commissioner
Mariano A. Mier Romeu Guaynabo 00968

Rhode Island Superintendent
Elizabeth Kelleher Dwyer Cranston 02920

South Carolina Director
Raymond G. Farmer Columbia 29201

South Dakota Director
Larry D. Deiter Pierre 57501

Tennessee Commissioner
Carter Lawrence Nashville 37243

Texas Chief Deputy Commissioner
Doug Slape Austin 78701

Utah Commissioner
Jonathan T. Pike Salt Lake City 84114

Vermont Commissioner
Michael S. Pieciak Montpelier 05620

Virgin Islands Lt. Governor/Commissioner
Tregenza A. Roach St. Thomas 00802

Virginia Commissioner
Scott A. White Richmond 23219

Washington Commissioner
Mike Kreidler Olympia 98504

West Virginia Commissioner
James A. Dodrill Charleston 25301

Wisconsin Commissioner
Mark Afable Madison 53703

Wyoming Commissioner
Jeff Rude Cheyenne 82002

Updated: 4/5/2021
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<th>MEMBER NAME</th>
<th>BEG. DATE</th>
<th>END DATE</th>
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<td>ALABAMA—Appointed, at the pleasure of the Governor; 6-Year Term</td>
<td>Jim L. Ridling</td>
<td>9/15/2008</td>
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### NAIC MEMBER TENURE LIST

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**AMERICAN SAMOA — Continued**

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

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### NAIC MEMBER TENURE LIST

#### ARIZONA—Continued

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

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<td>(Died May 22, 1929)</td>
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### NAIC Member Tenure List

#### Arkansas—Continued

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### NAIC MEMBER TENURE LIST

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#### COLORADO—Appointed, at the Pleasure of the Governor; 2-Year Term

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

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## NAIC MEMBER TENURE LIST

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<td>2/27/1885</td>
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<tr>
<td>Insurance Commissioner</td>
<td>(Died Feb. 1885)</td>
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<td></td>
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<tr>
<td>Insurance Commissioner</td>
<td>John R. McFee</td>
<td>4/21/1879</td>
<td>4/21/1883</td>
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<tr>
<td>Secretary of State</td>
<td>Ignatius C. Grubb</td>
<td>1/18/1875</td>
<td>4/21/1879</td>
<td>4</td>
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<tr>
<td>Secretary of State</td>
<td>John H. Paynter</td>
<td>5/24/1871</td>
<td>1/18/1875</td>
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#### DISTRICT OF COLUMBIA—Appointed, at the Pleasure of the Mayor

<table>
<thead>
<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioner, Dept. of Insurance, Securities &amp; Banking (DISB)</td>
<td>Karima M. Woods</td>
<td>7/28/2020</td>
<td>incumbent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acting Commissioner, DISB</td>
<td>Karima M. Woods</td>
<td>1/21/2020</td>
<td>7/28/2020</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Commissioner, DISB</td>
<td>Stephen C. Taylor</td>
<td>11/3/2015</td>
<td>1/20/2020</td>
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<tr>
<td>Acting Commissioner, DISB</td>
<td>Stephen C. Taylor</td>
<td>6/19/2015</td>
<td>11/3/2015</td>
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</tr>
<tr>
<td>Acting Commissioner, DISB</td>
<td>Chester A. McPherson</td>
<td>4/20/2014</td>
<td>6/19/2015</td>
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<tr>
<td>Interim Commissioner, DISB</td>
<td>Chester A. McPherson</td>
<td>11/15/2013</td>
<td>4/20/2014</td>
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<tr>
<td>Acting Commissioner, DISB</td>
<td>William P. White</td>
<td>2/14/2011</td>
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<tr>
<td>Acting Commissioner, DISB</td>
<td>Thomas E. Hampton</td>
<td>10/1/2005</td>
<td>5/9/2006</td>
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<tr>
<td>Commissioner, DISB</td>
<td>Lawrence H. ‘Larry’ Mirel</td>
<td>3/1/2004</td>
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<tr>
<td>Acting Cmrs. of Ins. &amp; Securities</td>
<td>Lawrence H. ‘Larry’ Mirel</td>
<td>7/6/1999</td>
<td>10/5/1999</td>
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<td>Acting Cmrs. of Ins. &amp; Securities</td>
<td>Reginald Berry</td>
<td>1/4/1999</td>
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<td>Commissioner of Ins. &amp; Securities</td>
<td>Patrick E. Kelly</td>
<td>7/21/1998</td>
<td>1/4/1999</td>
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<tr>
<td>Interim Cmrs. of Ins. &amp; Securities</td>
<td>Patrick E. Kelly</td>
<td>7/22/1997</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Margurite Stokes</td>
<td>4/1/1983</td>
<td>4/1/1991</td>
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### NAIC Member Tenure List

**District of Columbia—Continued**

<table>
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<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tbody>
<tr>
<td>Superintendent of Insurance</td>
<td>J. Balch Moor (Died July 22, 1939)</td>
<td>3/23/1936</td>
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<tr>
<td>Superintendent of Insurance</td>
<td>John A. Marshall</td>
<td>2/19/1934</td>
<td>3/23/1936</td>
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<tr>
<td>Superintendent of Insurance</td>
<td>Herbert L. Davis</td>
<td>5/1/1931</td>
<td>2/19/1934</td>
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<tr>
<td>Acting Superintendent of Insurance</td>
<td>Frank B. Bryan, Jr.</td>
<td>4/28/1931</td>
<td>5/1/1931</td>
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<tr>
<td>Superintendent of Insurance</td>
<td>Thomas M. Baldwin, Jr.</td>
<td>9/16/1924</td>
<td>4/28/1931</td>
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<tr>
<td>Acting Superintendent of Insurance</td>
<td>Thomas M. Baldwin, Jr.</td>
<td>3/29/1924</td>
<td>9/16/1924</td>
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<tr>
<td>Superintendent of Insurance</td>
<td>Burt A. Miller</td>
<td>6/22/1922</td>
<td>3/28/1924</td>
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<tr>
<td>Superintendent of Insurance</td>
<td>Lewis A. Griffith</td>
<td>6/4/1919</td>
<td>6/22/1922</td>
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<tr>
<td>Superintendent of Insurance</td>
<td>Lee B. Mosher</td>
<td>11/14/1917</td>
<td>5/7/1919</td>
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<tr>
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<td>Charles C. Wright</td>
<td>10/22/1917</td>
<td>11/14/1917</td>
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<tr>
<td>Superintendent of Insurance</td>
<td>Charles F. Nesbit</td>
<td>1/10/1914</td>
<td>10/22/1917</td>
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<tr>
<td>Superintendent of Insurance</td>
<td>George W. Ingham</td>
<td>11/17/1910</td>
<td>12/22/1913</td>
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<tr>
<td>Acting Superintendent of Insurance</td>
<td>Daniel E. Curry</td>
<td>7/23/1910</td>
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<tr>
<td>Superintendent of Insurance</td>
<td>Thomas E. Drake (Died July 23, 1910)</td>
<td>1/1/1902</td>
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<tr>
<td>Assessor of the District</td>
<td>Hopewell H. Darnelle</td>
<td>12/1/1899</td>
<td>12/31/1901</td>
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<tr>
<td>Assessor of the District</td>
<td>Matthew Trimble</td>
<td>3/16/1890</td>
<td>12/1/1899</td>
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<tr>
<td>Assessor of the District</td>
<td>Roger Williams</td>
<td>3/19/1889</td>
<td>3/16/1890</td>
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</tr>
<tr>
<td>Assessor of the District</td>
<td>Roswell A. Fish</td>
<td>5/23/1887</td>
<td>3/19/1889</td>
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<tr>
<td>Treasurer and Assessor</td>
<td>Robert P. Dodge (Died May 21, 1887)</td>
<td>7/11/1876</td>
<td>5/21/1887</td>
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<tr>
<td>Treasurer of the District</td>
<td>James S. Wilson</td>
<td>12/1/1873</td>
<td>7/11/1876</td>
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<tr>
<td>Treasurer of the District</td>
<td>John T. Johnson</td>
<td>10/18/1871</td>
<td>11/29/1873</td>
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**Florida—Appointed, at the Pleasure of the Financial Services Commission**

<table>
<thead>
<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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</thead>
<tbody>
<tr>
<td>Insurance Commissioner</td>
<td>David Altmairer</td>
<td>4/29/2016</td>
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<td>incumbent</td>
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</tr>
<tr>
<td>Insurance Commissioner</td>
<td>Kevin M. McCarty</td>
<td>1/9/2003</td>
<td>4/29/2016</td>
<td>13</td>
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<tr>
<td>State Treasurer/Ins. Commissioner</td>
<td>Broward Williams</td>
<td>1/25/1965</td>
<td>1/5/1971</td>
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<tr>
<td>State Treasurer/Ins. Commissioner</td>
<td>J. Edwin Larson (Died Jan. 24, 1965)</td>
<td>1/7/1941</td>
<td>1/24/1965</td>
<td>24</td>
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<tr>
<td>State Treasurer/Ins. Commissioner</td>
<td>William V. Knott</td>
<td>9/28/1928</td>
<td>1/7/1941</td>
<td>12</td>
<td>3</td>
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<tr>
<td>State Treasurer/Ins. Commissioner</td>
<td>John C. Luning (Died Sept. 26, 1928)</td>
<td>2/19/1912</td>
<td>9/26/1928</td>
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<tr>
<td>State Treasurer</td>
<td>William V. Knott</td>
<td>3/1/1903</td>
<td>2/19/1912</td>
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<tr>
<td>State Treasurer</td>
<td>James B. Whitfield</td>
<td>6/19/1897</td>
<td>3/1/1903</td>
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<tr>
<td>State Treasurer</td>
<td>Clarence B. Collins</td>
<td>1/3/1893</td>
<td>6/19/1897</td>
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<tr>
<td>State Treasurer</td>
<td>Eduardo J. Triay</td>
<td>12/31/1891</td>
<td>1/3/1893</td>
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### NAIC MEMBER TENURE LIST

<table>
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<tr>
<th>STATE/MEMBER TITLE</th>
<th>MEMBER NAME</th>
<th>BEG. DATE</th>
<th>END DATE</th>
<th>YRS. SERVED</th>
<th>MOS. SERVED</th>
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<tr>
<td><strong>FLORIDA</strong>—Continued</td>
<td>Francis J. Pons</td>
<td>1/8/1889</td>
<td>12/24/1891</td>
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<tr>
<td>State Treasurer</td>
<td>Edward S. Crill</td>
<td>2/19/1885</td>
<td>1/8/1889</td>
<td>3</td>
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<tr>
<td>State Treasurer</td>
<td>Henry A. L’Engle</td>
<td>2/1/1881</td>
<td>2/19/1885</td>
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<tr>
<td>State Treasurer</td>
<td>Walter H. Gwynn</td>
<td>1/9/1877</td>
<td>2/1/1881</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>State Treasurer</td>
<td>Charles H. Foster</td>
<td>1/16/1873</td>
<td>1/9/1877</td>
<td>4</td>
<td>0</td>
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<tr>
<td>State Treasurer</td>
<td>Simon B. Conover</td>
<td>5/24/1871</td>
<td>1/16/1873</td>
<td>1</td>
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<tr>
<td><strong>FLORIDA</strong> (Department of Financial Services)—Elected; 4-Year Term</td>
<td>Jimmy T. Patronis, Jr.</td>
<td>6/30/2017</td>
<td>incumbent</td>
<td></td>
<td></td>
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<tr>
<td>Chief Financial Officer</td>
<td>Jeffrey H. &quot;Jeff&quot; Atwater</td>
<td>1/4/2011</td>
<td>6/30/2017</td>
<td>6</td>
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<tr>
<td>Chief Financial Officer</td>
<td>Adelaide Alexander ‘Alex’ Sink</td>
<td>1/2/2007</td>
<td>1/4/2011</td>
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<tr>
<td><strong>GEORGIA</strong>—Elected; 4-Year Term</td>
<td>John F. King</td>
<td>7/1/2019</td>
<td>incumbent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance Commissioner</td>
<td>Jim Beck</td>
<td>1/14/2019</td>
<td>5/16/2019</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Ralph T. Hudgens</td>
<td>1/10/2011</td>
<td>1/13/2019</td>
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<tr>
<td>Insurance Commissioner</td>
<td>John Oxendine</td>
<td>1/20/1995</td>
<td>1/1/2011</td>
<td>16</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Tim Ryles</td>
<td>1/20/1991</td>
<td>1/20/1995</td>
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<tr>
<td>Ins. Cmsr./Comptroller General</td>
<td>Johnnie L. Caldwell</td>
<td>1/12/1971</td>
<td>11/1/1985</td>
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<tr>
<td>Ins. Cmsr./Comptroller-General</td>
<td>James L. Bentley</td>
<td>1/1/1963</td>
<td>11/1/1971</td>
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<tr>
<td>Ins. Cmsr./Comptroller-General</td>
<td>Zachariah D. ‘Zack’ Cravey</td>
<td>1/1/1947</td>
<td>1/1/1963</td>
<td>16</td>
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<tr>
<td>Ins. Cmsr./Comptroller-General</td>
<td>Homer C. Parker</td>
<td>1/14/1941</td>
<td>6/22/1946</td>
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<tr>
<td>Ins. Cmsr./Comptroller-General</td>
<td>C. Downing Musgrove</td>
<td>6/7/1940</td>
<td>1/14/1941</td>
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<tr>
<td>Ins. Cmsr./Comptroller-General</td>
<td>William B. Harrison</td>
<td>1/12/1937</td>
<td>6/3/1940</td>
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<td>Ins. Cmsr./Comptroller-General</td>
<td>Glenn B. Carreker</td>
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<tr>
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<td>William B. Harrison</td>
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<td>2/24/1936</td>
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<tr>
<td>Ins. Cmsr./Comptroller-General</td>
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<td>9/17/1879</td>
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<tr>
<td>Comptroller-General</td>
<td>Washington L. Goldsmith</td>
<td>1/11/1873</td>
<td>9/17/1879</td>
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<tr>
<td>Comptroller-General</td>
<td>Madison Bell</td>
<td>5/24/1871</td>
<td>1/11/1873</td>
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<tr>
<td><strong>GUAM</strong>—Appointed, at the Pleasure of the Governor</td>
<td>Michelle B. Santos</td>
<td>12/7/2020</td>
<td>incumbent</td>
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<tr>
<td>Cmsr. of Banking and Insurance</td>
<td>Dafne M. Shimizu</td>
<td>1/7/2019</td>
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<tr>
<td>Director of Rev. &amp; Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
<td>John P. Camacho</td>
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<tr>
<td>Director of Rev. &amp; Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
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</table>
## NAIC MEMBER TENURE LIST

<table>
<thead>
<tr>
<th>STATE/MEMBER TITLE</th>
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<tr>
<td><strong>GUAM—Continued</strong></td>
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<tr>
<td>Director of Rev. &amp; Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
<td>Artemio B. ‘Art’ Ilagan</td>
<td>1/1/2008</td>
<td>10/29/2008</td>
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<tr>
<td>Cmsr. of Banking and Insurance</td>
<td>John P. Camacho</td>
<td>6/26/2007</td>
<td>1/1/2008</td>
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<td>Acting Director of Revenue and Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
<td>George V. Cruz</td>
<td>9/28/2001</td>
<td>1/6/2003</td>
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<tr>
<td>Director of Revenue and Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
<td>Joseph T. ‘Joey’ Duenas</td>
<td>1/1/1995</td>
<td>9/28/2001</td>
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</tr>
<tr>
<td>Director of Revenue and Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
<td>Joaquin G. Blaz</td>
<td>1/1/1988</td>
<td>1/1/1995</td>
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<tr>
<td>Acting Director of Revenue and Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
<td>J.C. Carr Bettis</td>
<td>1/1/1987</td>
<td>1/1/1988</td>
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<tr>
<td>Director of Revenue and Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
<td>Jose R. Rivera</td>
<td>1/2/1981</td>
<td>1/3/1983</td>
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<tr>
<td>Director of Revenue and Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
<td>Ignacio C. Borja</td>
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<td>1/2/1981</td>
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### IDAHO—Appointed; Four Years, Subject to Earlier Removal by the Governor

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<th>KANSAS—Elected; 4-Year Term</th>
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<tr>
<td>Commissioner of Insurance</td>
<td>Vicki Schmidt (Elected Nov. 6, 2018)</td>
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<td>Commissioner of Insurance</td>
<td>Kenneth A. ‘Ken’ Selzer</td>
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<td>Frank Sullivan</td>
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# NAIC Member Tenure List

## Kansas—Continued

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

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### NAIC MEMBER TENURE LIST

#### KENTUCKY—Continued

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#### LOUISIANA—Elected, 4-Year Term

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### NAIC MEMBER TENURE LIST

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# NAIC Member Tenure List

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

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Begin Date</th>
<th>End Date</th>
<th>Years Served</th>
<th>Months Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioner of Insurance</td>
<td>Gary D. Anderson</td>
<td>10/31/2017</td>
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<td>incumbent</td>
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<tr>
<td>Acting Commissioner of Insurance</td>
<td>Gary D. Anderson</td>
<td>2/23/2017</td>
<td>10/31/2017</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Daniel R. Judson</td>
<td>4/1/2015</td>
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<td>Nonnie Burns</td>
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<td>Commissioner of Insurance</td>
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<td>Linda L. Ruthardt</td>
<td>8/1/1993</td>
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<td>Commissioner of Insurance</td>
<td>Timothy H. Gailey</td>
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<td>Roger M. Singer</td>
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<td>Edmund S. Cogswell</td>
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<td>Francis J. DeCelles</td>
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<td>Merton L. Brown</td>
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<td>Arthur E. Linnell</td>
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<td>Wesley E. Monk</td>
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<td>9/1/1919</td>
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<td>Frank H. Hardson</td>
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<td>Frederick L. “Fred” Cutting</td>
<td>9/30/1897</td>
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<td>Insurance Commissioner</td>
<td>George S. Merrill</td>
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<td>Insurance Commissioner</td>
<td>John K. Tarbox (Died May 28, 1887)</td>
<td>4/21/1883</td>
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<td>Insurance Commissioner</td>
<td>Julius L. Clarke</td>
<td>5/24/1871</td>
<td>2/14/1883</td>
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## Michigan—Appointed, at the Pleasure of the Governor; 4-Year Term

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<tr>
<th>Role</th>
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<th>Years Served</th>
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<tr>
<td>Director, Department of Insurance and Financial Services (DIFS)</td>
<td>Anita G. Fox</td>
<td>1/14/2019</td>
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<td>Acting Director, DIFS</td>
<td>Judith A. ‘Judy’ Weaver</td>
<td>12/28/2018</td>
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<td>Patrick M. McPharlin</td>
<td>5/18/2015</td>
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<td>Director, DIFS</td>
<td>Annette E. Flood</td>
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<td>5/18/2015</td>
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<td>Director, DIFS</td>
<td>R. Kevin Clinton</td>
<td>3/18/2013</td>
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<td>2/21/2008</td>
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<td>Ronald C. Jones, Jr.</td>
<td>2/1/2003</td>
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## NAIC MEMBER TENURE LIST

### MICHIGAN—Continued

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<th>Mos. Served</th>
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<td>Allen L. Mayerson</td>
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### MINNESOTA—Appointed, at the Pleasure of the Governor; Confirmed by the Senate

<table>
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<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
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<tr>
<td>Temporary Cmrs. of Commerce</td>
<td>Grace Arnold</td>
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<tr>
<td>Commissioner of Commerce</td>
<td>Steve Kelley</td>
<td>1/7/2019</td>
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<td>Commissioner of Commerce</td>
<td>Jessica Looman</td>
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<td>Michael J. ‘Mike’ Rothman</td>
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<td>Glenn Wilson, Jr.</td>
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<td>Cyrus E. Magnusson</td>
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<td>Cyril C. Sheehan</td>
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<td>A. Herbert Nelson</td>
<td>5/15/1951</td>
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### NAIC Member Tenure List

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**MONTANA—Elected: 4-Year Term**

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<td>John Morrison</td>
<td>1/1/2001</td>
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<td>Cmsr. of Insurance/State Auditor</td>
<td>Mark D. O’Keefe</td>
<td>1/4/1993</td>
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<td>Andrea M. ‘Andy’ Bennett</td>
<td>1/7/1985</td>
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<td>Cmsr. of Insurance/State Auditor</td>
<td>Elmer V. ‘Sonny’ Omholt</td>
<td>5/21/1962</td>
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### NAIC MEMBER TENURE LIST

#### MONTANA—Continued

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<td>John J. Holmes</td>
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<td>George P. Porter</td>
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<td>Rufus G. Poland</td>
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<td>Charles M. McCoy</td>
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<td>Henry R. Cunningham</td>
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<td>Andrew B. Cook</td>
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<td>Edwin A. Kenney</td>
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#### NEBRASKA—Appointed, at the Pleasure of the Governor

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<td>Bruce R. Ramge</td>
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<tr>
<td>Bruce R. Ramge</td>
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<tr>
<td>Ann M. Frohman</td>
<td>Director of Insurance</td>
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<td>L. Timothy ‘Tim’ Wagner</td>
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<td>Robert G. Lange</td>
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<td>Michael J. Dugan</td>
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<td>M. Berri Balka</td>
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<td>James M. Jackson</td>
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<td>Samuel ‘Sam’ Van Pelt</td>
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<td>Benjamin C. ‘Ben’ Neff, Jr.</td>
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<td>Frank J. Barrett</td>
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<td>William E. Grubbs</td>
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<td>John H. Binning</td>
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<td>Loren H. Laughlin</td>
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<td>Cecil C. Frazier</td>
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<td>John S. Logan</td>
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<td>Robert E. Lee ‘Lee’ Herdman</td>
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<td>Robert E. Lee ‘Lee’ Herdman</td>
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<td>Lloyd C. Dort</td>
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<td>Mary A. Fairchild</td>
<td>Acting Chief, Bureau of Insurance</td>
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## NAIC MEMBER TENURE LIST

**NEBRASKA—Continued**

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<th>Mos. Served</th>
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<td>Chief, Bureau of Insurance</td>
<td>W. Bruce Young</td>
<td>8/23/1919</td>
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<td>William B. Eastham</td>
<td>7/23/1915</td>
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<td>Secretary of Insurance Board /Insurance Commissioner</td>
<td>Lawson G. Brian</td>
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<td>Frederick W. Liedtke</td>
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<td>John Gillespie</td>
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**NEVADA—Appointed, at the Pleasure of the Director of the Department of Business and Industry**

<table>
<thead>
<tr>
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<th>Barbara D. Richardson</th>
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<tr>
<td>Acting Insurance Commissioner</td>
<td>Amy L. Parks</td>
<td>7/7/2015</td>
<td>3/7/2016</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Scott J. Kipper</td>
<td>10/24/2011</td>
<td>7/2/2015</td>
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<tr>
<td>Acting Insurance Commissioner</td>
<td>Amy L. Parks</td>
<td>8/12/2011</td>
<td>10/24/2011</td>
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<td>Insurance Commissioner</td>
<td>Brett J. Barratt</td>
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<td>7/1/2011</td>
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<tr>
<td>Acting Insurance Commissioner</td>
<td>Betty Baker</td>
<td>9/1/2008</td>
<td>12/29/2008</td>
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<td>Insurance Commissioner</td>
<td>Alice Molasky-Arman</td>
<td>1/6/1995</td>
<td>9/1/2008</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Alessandro A. ‘Al’ Iuppa</td>
<td>1/1/1990</td>
<td>2/1/1991</td>
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<td>David A. Gates</td>
<td>7/6/1984</td>
<td>1/1/1990</td>
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<td>Kevin Sullivan</td>
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<td>7/6/1984</td>
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<td>Patsy Redmond</td>
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<td>1/3/1983</td>
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<td>5/12/1981</td>
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<td>Paul A. Hammel (Died April 21, 1965)</td>
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| Deputy Controller | Paul A. Hammel (Died April 21, 1965) | 1/1/1951 | 4/1/1951 | 0 | 3 |
| State Comptroller | Jerome P. ‘Jerry’ Donovan | 12/1/1947 | 1/1/1951 | 3 | 5 |
| State Comptroller | Edward C. Peterson | 1/3/1927 | 1/8/1935 | 8 | 0 |
| State Comptroller | George A. Cole | 1/1/1915 | 1/1/1927 | 12 | 0 |
| State Comptroller | Jacob Eggers | 1/1/1907 | 1/1/1915 | 8 | 0 |
| State Comptroller | Samuel P. Davis | 1/1/1899 | 1/1/1907 | 8 | 0 |
| State Comptroller | C. A. LaGrave | 1/1/1895 | 1/1/1899 | 4 | 0 |
| State Comptroller | Robert L. Horton | 1/1/1891 | 1/1/1895 | 4 | 0 |
| State Comptroller | James F. Hallock | 1/1/1879 | 1/1/1891 | 12 | 0 |
| State Comptroller | William W. Hobart | 5/24/1871 | 1/1/1879 | 7 | 8 |
### NAIC MEMBER TENURE LIST

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<th>END DATE</th>
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<th>MOS. SERVED</th>
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<tr>
<td>Insurance Commissioner</td>
<td>Christopher R. ‘Chris’ Nicolopoulos</td>
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<tr>
<td>Acting Insurance Commissioner</td>
<td>Alexander K. ‘Alex’ Feldvebel</td>
<td>1/1/2020</td>
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<td>Paula T. Rogers</td>
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<td>Donald ‘Don’ Knowlton</td>
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<td>Simon M. Sheldon</td>
<td>4/30/1943</td>
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<td>Arthur J. Rouillard</td>
<td>9/17/1937</td>
<td>4/30/1943</td>
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<td>John E. Sullivan (Died Sept. 6, 1937)</td>
<td>6/16/1931</td>
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<td>Acting Insurance Commissioner</td>
<td>William N. Johnston</td>
<td>9/26/1930</td>
<td>6/16/1931</td>
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<td>John E. Sullivan (Died May 8, 1923)</td>
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<td>9/25/1905</td>
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<td>Insurance Commissioner</td>
<td>John C. Linehan (Died Sept. 19, 1905)</td>
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<td>6/27/2018</td>
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## NAIC MEMBER TENURE LIST

### NEW JERSEY—Continued

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<td>Cmsr. of Banking and Insurance</td>
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<td>Cmsr. of Banking and Insurance</td>
<td>Warren G. Gaffney</td>
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<td>Christopher A. Gough</td>
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<td>Secretary of State</td>
<td>Henry C. Kelsey</td>
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### NEW MEXICO—Appointed, by the Insurance Nominating Committee; 4-Year Term

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<td>Interim Superintendent of Insurance</td>
<td>Craig Dunbar</td>
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© 2021 National Association of Insurance Commissioners
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<td>Cleofias Romero</td>
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<td>New York—Appointed, at the Pleasure of the Governor</td>
<td>Superintendent of Financial Services</td>
<td>Linda A. Lacewell</td>
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<td>Acting Superintendent of Insurance</td>
<td>Wendy E. Cooper</td>
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<td>Albert B. Lewis</td>
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<tr>
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<tr>
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<td>Lawrence W. Keepnews</td>
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<td>Superintendent of Insurance</td>
<td>Benjamin R. Schenck</td>
<td>1/1/1971</td>
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<td>Superintendent of Insurance</td>
<td>Henry Root Stern, Jr.</td>
<td>1/28/1964</td>
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<td>Julius S. Wikler</td>
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<td>Adelbert G. Straub, Jr.</td>
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<td>Alfred J. Bohlinger</td>
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<td>Acting Superintendent of Insurance</td>
<td>Thomas J. Cullen</td>
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<td>Louis H. Pink</td>
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<td>Francis R. Stoddard, Jr.</td>
<td>12/1/1921</td>
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<td>Henry D. Appleton</td>
<td>11/1/1921</td>
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<td>Jesse S. Phillips</td>
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<td>Frank Hasbrouck</td>
<td>3/27/1914</td>
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<td>William Temple Emmet</td>
<td>2/21/1912</td>
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<td>William H. Hotchkiss</td>
<td>2/18/1909</td>
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<td>Superintendent of Insurance</td>
<td>Otto Kelsey</td>
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<td>Superintendent of Insurance</td>
<td>Francis Hendricks</td>
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<td>Superintendent of Insurance</td>
<td>Louis F. Payn</td>
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<td>James F. Pierce</td>
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<td>Robert A. Maxwell</td>
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<td>Superintendent of Insurance</td>
<td>John A. McCall, Jr.</td>
<td>4/23/1883</td>
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<td>Superintendent of Insurance</td>
<td>Charles G. Fairman</td>
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<td>Superintendent of Insurance</td>
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<td>Superintendent of Insurance</td>
<td>Orlow W. Chapman</td>
<td>11/29/1872</td>
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<td>Superintendent of Insurance</td>
<td>George B. Church</td>
<td>5/13/1872</td>
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<td>Superintendent of Insurance</td>
<td>George W. Miller</td>
<td>5/24/1871</td>
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## NAIC MEMBER TENURE LIST

**NORTH CAROLINA—Elected: 4-Year Term**

<table>
<thead>
<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
</tr>
</thead>
</table>
| Commissioner of Insurance           | Mike Causey  
( Elected Nov. 8, 2016;  
Re-elected Nov. 3, 2020)   | 1/1/2017  |          | incumbent  |             |
| Commissioner of Insurance           | G. Wayne Goodwin                                | 1/10/2009 | 1/1/2017 | 8           | 0           |
| Commissioner of Insurance           | John Randolph Ingram                           | 1/10/1973 | 1/5/1985 | 12          | 0           |
| Commissioner of Insurance           | Edwin S. Lanier                                | 7/16/1962 | 1/10/1973| 10          | 6           |
| Commissioner of Insurance           | Charles F. Gold                                | 6/1/1953  | 7/16/1962| 9            | 1           |
| Commissioner of Insurance           | Waldo C. Cheek                                  | 6/1/1949  | 6/1/1953 | 4            | 0           |
| Commissioner of Insurance           | William P. ‘Bill’ Hodges                       | 9/1/1942  | 6/1/1949 | 6            | 9           |
| Commissioner of Insurance           | Daniel C. ‘Dan’ Boney                          | 11/15/1927| 9/1/1942 | 14           | 10          |
| Commissioner of Insurance           | Stacey W. Wade                                 | 1/1/1921  | 11/15/1927| 6            | 10          |
| Commissioner of Insurance           | James R. Young                                 | 1/1/1899  | 1/1/1921 | 22           | 0           |
| Secretary of State                  | Cyrus Thompson                                 | 1/1/1897  | 1/1/1899 | 2            | 0           |
| Secretary of State                  | C. M. Cooke                                    | 8/1/1895  | 1/1/1897 | 1            | 5           |
| Secretary of State                  | Octavius Coke                                  | 4/1/1891  | 8/1/1895 | 4            | 4           |
| Secretary of State                  | William L. Saunders                            | 1/1/1879  | 4/1/1891 | 12           | 3           |
| Secretary of State                  | J. A. Englehard                                | 1/1/1877  | 1/1/1879 | 2            | 0           |
| Secretary of State                  | W. H. Howerton                                 | 1/1/1873  | 1/1/1877 | 4            | 0           |
| Secretary of State                  | No Record in Proceedings  
(Represented by Special Delegate  
William H. Finch) | 10/1/1871 | 1/1/1873 | 1            | 3           |

**NORTH DAKOTA—Elected: 4-Year Term**

<table>
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<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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</thead>
</table>
| Commissioner of Insurance           | Jon Godfread  
( Elected Nov. 8, 2016;  
Re-elected Nov. 3, 2020)   | 1/3/2017  |          | incumbent  |             |
| Commissioner of Insurance           | Adam Hamm                                     | 10/9/2007 | 1/3/2017 | 9           | 3           |
| Acting Commissioner of Insurance    | Rebecca Ternes                                | 9/1/2007  | 10/9/2007| 0            | 1           |
| Commissioner of Insurance           | James A. ‘Jim’ Poolman                        | 1/1/2001  | 8/31/2007| 6            | 8           |
| Commissioner of Insurance           | Glenn Pomeroy                                 | 1/1/1993  | 1/1/2001 | 8            | 0           |
| Commissioner of Insurance           | Earl R. Pomeroy                               | 1/1/1985  | 1/1/1993 | 8            | 0           |
| Commissioner of Insurance           | Jorris O. Wigen                              | 1/1/1981  | 1/1/1985 | 4            | 0           |
| Commissioner of Insurance           | Byron Knutson                                 | 1/1/1977  | 1/1/1981 | 4            | 0           |
| Commissioner of Insurance           | Jorris O. Wigen                              | 1/1/1969  | 1/1/1977 | 8            | 0           |
| Commissioner of Insurance           | Karsten O. Nygaard                            | 1/1/1965  | 1/1/1969 | 4            | 0           |
| Commissioner of Insurance           | Frank Albers                                  | 1/1/1963  | 1/1/1965 | 2            | 0           |
| Commissioner of Insurance           | Alfred J. Jensen                              | 1/1/1951  | 1/1/1963 | 12           | 0           |
| Commissioner of Insurance           | Otto G. Krueger                               | 9/7/1945  | 1/1/1951 | 5            | 4           |
| Commissioner of Insurance           | Oscar E. Erickson  
( Died Aug 15, 1945) | 1/1/1937  | 8/15/1945| 8            | 7           |
| Commissioner of Insurance           | Harold L. Hopton                              | 1/7/1935  | 1/11/1937| 2            | 0           |
| Commissioner of Insurance           | Sveinung A. Olsness                          | 1/2/1917  | 1/7/1935 | 18           | 0           |
| Commissioner of Insurance           | Walter C. Taylor                              | 1/1/1911  | 1/2/1917 | 6            | 0           |
| Commissioner of Insurance           | Ernest C. Cooper                              | 1/1/1905  | 12/31/1910| 6            | 0           |
| Commissioner of Insurance           | Ferdinand ‘Ferd’ Leutz                       | 1/1/1901  | 12/31/1904| 4            | 0           |
| Commissioner of Insurance           | George W. Harrison                            | 1/3/1899  | 12/31/1900| 2            | 0           |
| Commissioner of Insurance           | Frederick B. ‘Fred’ Fancher                   | 1/7/1895  | 1/3/1899 | 4            | 0           |
| Commissioner of Insurance           | James ‘Jim’ Cudhie                            | 1/3/1893  | 1/7/1895 | 2            | 0           |
| Territorial Auditor                | John C. McManima                              | 9/4/1889  | 11/4/1889| 0            | 2           |
## NAIC MEMBER TENURE LIST

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

<table>
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<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tbody>
<tr>
<td>Acting Secretary of Commerce</td>
<td>Edward M. Deleon Guerrero</td>
<td>3/28/2021</td>
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<tr>
<td>Secretary of Commerce</td>
<td>Mark O. Rabauliman</td>
<td>3/6/2015</td>
<td>3/26/2021</td>
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<tr>
<td>Acting Secretary of Commerce</td>
<td>Mark O. Rabauliman</td>
<td>9/9/2014</td>
<td>3/6/2015</td>
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<tr>
<td>Secretary of Commerce</td>
<td>Sixto K. Igsomar</td>
<td>1/24/2012</td>
<td>9/9/2014</td>
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<tr>
<td>Acting Secretary of Commerce</td>
<td>Sixto K. Igsomar</td>
<td>10/8/2010</td>
<td>1/24/2012</td>
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<tr>
<td>Secretary of Commerce</td>
<td>Michael J. Ada</td>
<td>9/18/2008</td>
<td>10/8/2010</td>
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<tr>
<td>Acting Secretary of Commerce</td>
<td>Michael J. Ada</td>
<td>8/15/2008</td>
<td>9/18/2008</td>
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<tr>
<td>Secretary of Commerce</td>
<td>James A. Santos</td>
<td>5/8/2006</td>
<td>8/15/2008</td>
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<tr>
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<td>James A. Santos</td>
<td>1/9/2006</td>
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<tr>
<td>Secretary of Commerce</td>
<td>Andrew S. Salas</td>
<td>1/1/2006</td>
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### OHIO—Appointed, at the Pleasure of the Governor; Confirmed by the Senate

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<th>State/Member Title</th>
<th>Member Name</th>
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<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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</thead>
<tbody>
<tr>
<td>Director of Insurance</td>
<td>Judith L. French</td>
<td>2/8/2021</td>
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<td>incumbent</td>
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<tr>
<td>Interim Director of Insurance</td>
<td>Tynesia Dorsey</td>
<td>8/24/2020</td>
<td>2/7/2021</td>
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<tr>
<td>Director of Insurance</td>
<td>Jillian E. Froment</td>
<td>3/31/2017</td>
<td>8/24/2020</td>
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<tr>
<td>Lt. Governor/Director of Insurance</td>
<td>Mary Taylor</td>
<td>1/10/2011</td>
<td>3/31/2017</td>
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<tr>
<td>Director of Insurance</td>
<td>Mary Jo Hudson</td>
<td>1/8/2007</td>
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<tr>
<td>Director of Insurance</td>
<td>Ann H. Womer Benjamin</td>
<td>1/6/2003</td>
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<tr>
<td>Interim Director of Insurance</td>
<td>Holly Saelens</td>
<td>11/29/2002</td>
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<td>J. Lee Covington II</td>
<td>5/7/1999</td>
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<tr>
<td>Interim Director of Insurance</td>
<td>Alan F. Berliner</td>
<td>4/1/1999</td>
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<td>David S. Meyer</td>
<td>1/11/1999</td>
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<td>Harold T. Duryee</td>
<td>3/1/1991</td>
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<tr>
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<td>Dana Rudmose</td>
<td>1/14/1991</td>
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<td>George Fabe</td>
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<tr>
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<td>Robert L. Ratchford, Jr.</td>
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<tr>
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<td>Kenneth E. ‘Ken’ DeShetler</td>
<td>1/11/1971</td>
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<td>Fred B. Smith</td>
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<td>1/16/1957</td>
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<td>August ‘Augie’ Pryatel</td>
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<td>W. Lee Shield</td>
<td>1/13/1947</td>
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<td>Walter Dressel</td>
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<tr>
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<td>William C. Safford</td>
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<td>Harry L. Conn</td>
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## NAIC Member Tenure List

### Ohio—Continued

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<th>State/Member Title</th>
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<td>Superintendent of Insurance</td>
<td>Robert T. Crew</td>
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### Oklahoma—Elected; 4-Year Term

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<tr>
<td>Insurance Commissioner</td>
<td>Glen Mulready (Elected Nov. 6, 2018)</td>
<td>1/14/2019</td>
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<td>Insurance Commissioner</td>
<td>John D. Doak</td>
<td>1/10/2011</td>
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<td>Kim Holland</td>
<td>1/24/2005</td>
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<td>9/24/2004</td>
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<td>Insurance Commissioner</td>
<td>Carroll Fisher</td>
<td>1/1/1999</td>
<td>9/24/2004</td>
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<tr>
<td>Insurance Commissioner</td>
<td>John P. Crawford</td>
<td>1/1/1995</td>
<td>1/1/1999</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Catherine J. ‘Cathy’ Weatherford</td>
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<td>Insurance Commissioner</td>
<td>Gerald Grimes</td>
<td>1/1/1975</td>
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<td>Insurance Commissioner</td>
<td>Joe B. Hunt</td>
<td>1/1/1955</td>
<td>1/1/1975</td>
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<td>Insurance Commissioner</td>
<td>Robert L. Birdwell</td>
<td>6/1/1954</td>
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<td>Donald F. Dickey</td>
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<td>E. W. Hardin</td>
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<td>T. J. McComb</td>
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<td>Robert Martin</td>
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### Oregon—Appointed, Indefinite

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<tr>
<td>Director, Department of Consumer and Business Services (DCBS) / Insurance Commissioner</td>
<td>Andrew R. Stolfi</td>
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### NAIC MEMBER TENURE LIST

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<td>Acting Director, Department of Consumer and Business Services (DCBS) / Commissioner of Insurance</td>
<td>Cameron Smith</td>
<td>12/21/2017</td>
<td>1/31/2018</td>
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<td>Jean Straight</td>
<td>9/1/2017</td>
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<td>Laura N. Cali Robison</td>
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### NAIC MEMBER TENURE LIST

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<td>Randy Rohrbough</td>
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<tr>
<td>Acting Commissioner of Insurance</td>
<td>Anthony A. Geyelin</td>
<td>9/26/1983</td>
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<td>John J. Sheehy</td>
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<td>Herbert S. Denenberg</td>
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<td>Commissioner of Insurance</td>
<td>Matthew H. Taggart (Died July 3, 1942)</td>
<td>1/17/1939</td>
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<td>1/15/1935</td>
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<td>Commissioner of Insurance</td>
<td>Einar Barford</td>
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# NAIC Member Tenure List

## Pennsylvania—Continued

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<th>Mos. Served</th>
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<td>Commissioner of Insurance</td>
<td>Charles Johnson</td>
<td>11/15/1911</td>
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<td>7/1/1905</td>
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<td>Commissioner of Insurance</td>
<td>Israel W. Durham</td>
<td>1/18/1899</td>
<td>6/30/1905</td>
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<td>James H. Lambert</td>
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<td>George B. Luper</td>
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<td>Commissioner of Insurance</td>
<td>John Montgomery Forster</td>
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<td>Auditor General</td>
<td>J. F. Hartranft</td>
<td>5/24/1871</td>
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## Puerto Rico—Appointed, Indefinite

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<tr>
<td>Commissioner of Insurance</td>
<td>Mariano A. Mier Romeu</td>
<td>1/4/2021</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Rafael Cester-Lopategui</td>
<td>9/10/2020</td>
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<td>Acting Commissioner of Insurance</td>
<td>Rafael Cester-Lopategui</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Javier Rivera Rios</td>
<td>1/17/2017</td>
<td>1/22/2020</td>
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<td>Commissioner of Insurance</td>
<td>Angela Wayne</td>
<td>1/2/2013</td>
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<td>Commissioner of Insurance</td>
<td>Ramón L. Cruz-Colón</td>
<td>1/4/2009</td>
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<td>Commissioner of Insurance</td>
<td>Dorellis Juarbe Jiménez</td>
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<td>Fermín M. Contreras Gómez</td>
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<td>Juan Antonio Garcia</td>
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<td>Miguel A. Villafañe-Neriz</td>
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<td>Jorge Soto Garcia</td>
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<td>Pablo J. Lopez Castro</td>
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<tr>
<td>Superintendent of Insurance</td>
<td>Jorge Font Saldana</td>
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<td>Lorenzo J. Noa</td>
<td>1/9/1943</td>
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<td>Superintendent of Insurance</td>
<td>Hector R. Ball</td>
<td>5/24/1933</td>
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## Rhode Island—Appointed, at the Discretion of the Director of Business Regulation

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<tr>
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<th>Yrs. Served</th>
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<tr>
<td>Superintendent of Insurance</td>
<td>Elizabeth ‘Beth’ Kelleher Dwyer</td>
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<tr>
<td>Deputy Director/Insurance and Banking Superintendent</td>
<td>Joseph Torti III</td>
<td>12/16/2002</td>
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<td>Superintendent of Insurance</td>
<td>Charles P. Kwolek, Jr.</td>
<td>11/19/1991</td>
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<td>Maurice C. Paradis</td>
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<td>Clifton A. Moore</td>
<td>2/1/1985</td>
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<td>William F. Carroll</td>
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<td>Peter F. Mullaney</td>
<td>1/10/1969</td>
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<td>RHODE ISLAND—Continued</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Thomas J. Coyle</td>
<td>1/9/1961</td>
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<td>Insurance Commissioner</td>
<td>Hartley F. Roberts</td>
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<td>1/20/1959</td>
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<td>J. Austin Carroll</td>
<td>7/1/1942</td>
<td>2/1/1947</td>
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<td>3/1/1939</td>
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<td>Chief, Division of Banking &amp; Ins.</td>
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<td>Philip H. Wilbour</td>
<td>4/8/1929</td>
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<td>Samuel H. Cross</td>
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<tbody>
<tr>
<td>Director of Insurance</td>
<td>Raymond G. 'Ray' Farmer (Reappointed Dec. 14, 2018)</td>
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<tr>
<td>Acting Director of Insurance</td>
<td>Gwendolyn Fuller McGriff</td>
</tr>
<tr>
<td>Director of Insurance</td>
<td>David Black</td>
</tr>
<tr>
<td>Director of Insurance</td>
<td>Scott H. Richardson</td>
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<tr>
<td>Director of Insurance</td>
<td>Eleanor Kitzman</td>
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<tr>
<td>Co-Acting Director of Insurance</td>
<td>Gwendolyn Fuller &amp; Tim Baker</td>
</tr>
<tr>
<td>Director of Insurance</td>
<td>Ernst N. 'Ernie' Csiszar</td>
</tr>
<tr>
<td>Director of Insurance</td>
<td>Lee P. Jedziniak</td>
</tr>
<tr>
<td>Director of Insurance</td>
<td>Susanne K. Murphy</td>
</tr>
<tr>
<td>Director of Insurance</td>
<td>John G. Richards</td>
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<td>Acting Commissioner of Insurance</td>
<td>Rogers T. Smith</td>
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<td>Commissioner of Insurance</td>
<td>John W. Lindsay</td>
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<td>Comptroller General of State</td>
<td>Johnson Hagood</td>
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<tr>
<td>Comptroller General of State</td>
<td>J. L. Neagle</td>
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<tr>
<td>SOUTH DAKOTA—Appointed, at the Pleasure of the Secretary of the Department of Labor and Regulation</td>
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<tr>
<td>Director of Insurance</td>
<td>Larry D. Deiter</td>
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<tr>
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<td>Larry D. Deiter</td>
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<tr>
<td>Director of Insurance</td>
<td>Merle D. Scheiber</td>
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<tr>
<td>Director of Insurance</td>
<td>Gary L. Steuck</td>
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<td>Wendell Malsam</td>
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<tr>
<td>Director of Insurance</td>
<td>Darla L. Lyon</td>
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<tr>
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<tr>
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<td>Mary Jane Cleary</td>
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<td>Susan L. Walker</td>
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<td>Randolph Bagby</td>
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<td>Clyde R. Horswill</td>
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<td>Commissioner of Insurance</td>
<td>Donald C. ‘Don’ Lewis</td>
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<td>Commissioner of Insurance</td>
<td>William N. Van Camp</td>
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## NAIC MEMBER TENURE LIST

### SOUTH DAKOTA — Continued

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<td>11/2/1889</td>
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<td>Territorial Auditor</td>
<td>John C. McManima</td>
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### TENNESSEE — Appointed, at the Discretion of the Governor

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<td>Cmr. of Commerce and Insurance</td>
<td>Carter Lawrence</td>
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<td>Cmr. of Commerce and Insurance</td>
<td>Paula A. Flowers</td>
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<td>Cmr. of Commerce and Insurance</td>
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<td>Cmr. of Commerce and Insurance</td>
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<td>Insurance Commissioner</td>
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<td>G. Thomas ‘Tom’ Taylor</td>
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<td>TENNESSEE—Continued</td>
<td>Edward B. Craig</td>
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<td>State Treasurer/Ins. Commissioner</td>
<td>Atha Thomas</td>
<td>10/26/1886</td>
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<td>Marshall T. Polk</td>
<td>2/8/1877</td>
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<td>TEXAS—Appointed; 2-Year Term</td>
<td>J. Douglas ‘Doug’ Slape</td>
<td>9/28/2020</td>
<td>Incumbent</td>
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<tr>
<td>Chief Deputy Commissioner</td>
<td>Kent Sullivan</td>
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<td>Omicron P. Lockhart</td>
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<td>Commissioner of Life Insurance/Chairman of the Board</td>
<td>R. L. Daniel</td>
<td>2/10/1933</td>
<td>3/1/1939</td>
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<tr>
<td>Commissioner of Life Insurance/Chairman of the Board</td>
<td>William A. Tarver</td>
<td>5/2/1929</td>
<td>2/10/1933</td>
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<tr>
<td>Commissioner of Life Insurance/Chairman of the Board</td>
<td>Robert B. Cousins, Jr.</td>
<td>9/1/1927</td>
<td>5/1/1929</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>R. L. Daniel</td>
<td>10/1/1925</td>
<td>9/1/1927</td>
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<td>11</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>John M. Scott</td>
<td>8/21/1923</td>
<td>10/1/1925</td>
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</tr>
<tr>
<td>Cmsr. of Insurance and Banking</td>
<td>James L. Chapman</td>
<td>9/1/1922</td>
<td>8/21/1923</td>
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<tr>
<td>Cmsr. of Insurance and Banking</td>
<td>Edward ‘Ed’ Hall</td>
<td>1/20/1921</td>
<td>9/1/1922</td>
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<td>Cmsr. of Insurance and Banking</td>
<td>J. T. McMillan</td>
<td>8/1/1920</td>
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<td>John C. Chidsey</td>
<td>4/1/1920</td>
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<td>Cmsr. of Insurance and Banking</td>
<td>George Waverly Briggs</td>
<td>2/1/1919</td>
<td>4/1/1920</td>
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<td>Cmsr. of Insurance and Banking</td>
<td>Charles O. Austin</td>
<td>8/31/1916</td>
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<td>Cmsr. of Insurance and Banking</td>
<td>John S. Patterson (Died Aug. 29, 1916)</td>
<td>1/20/1915</td>
<td>8/29/1916</td>
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<td>Cmsr. of Insurance and Banking</td>
<td>William W. Collier</td>
<td>7/22/1913</td>
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<tr>
<td>Cmsr. of Insurance and Banking</td>
<td>Bennett L. ‘Ben’ Gill</td>
<td>1/17/1911</td>
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<td>Frederick C. von Rosenburg</td>
<td>8/4/1910</td>
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<tr>
<td>Commissioner of Agriculture, Insurance, Statistics and History</td>
<td>Robert T. Milner</td>
<td>8/1/1906</td>
<td>8/31/1907</td>
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<tr>
<td>Commissioner of Agriculture, Insurance, Statistics and History</td>
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<td>8/1/1906</td>
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<tr>
<td>Commissioner of Agriculture, Insurance, Statistics and History</td>
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<td>8/1/1897</td>
<td>8/1/1901</td>
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<tr>
<td>Commissioner of Agriculture, Insurance, Statistics and History</td>
<td>Archibald J. Rose</td>
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<tr>
<td>Commissioner of Agriculture, Insurance, Statistics and History</td>
<td>John E. Hollingsworth</td>
<td>5/15/1891</td>
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<tr>
<td>Commissioner of Agriculture, Insurance, Statistics and History</td>
<td>Lafayette L. Foster</td>
<td>1/21/1887</td>
<td>5/5/1891</td>
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<tr>
<td>Commissioner of Agriculture, Insurance, Statistics and History</td>
<td>Hamilton P. Bee</td>
<td>12/30/1884</td>
<td>1/21/1887</td>
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</tr>
<tr>
<td>Commissioner of Agriculture, Insurance, Statistics and History</td>
<td>Henry P. Brewster (Died Dec. 26, 1884)</td>
<td>1/31/1883</td>
<td>12/26/1884</td>
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<tr>
<td>Commissioner of Agriculture, Insurance, Statistics and History</td>
<td>Ashley W. Spaight</td>
<td>1/26/1881</td>
<td>1/31/1883</td>
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<tr>
<td>Commissioner of Agriculture, Insurance, Statistics and History</td>
<td>Valentine O. King</td>
<td>9/17/1879</td>
<td>1/26/1881</td>
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### UTAH — Appointed, at the Pleasure of the Governor

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<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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</thead>
<tbody>
<tr>
<td>Commissioner of Insurance</td>
<td>Jonathan T. ‘Jon’ Pike</td>
<td>2/4/2021</td>
<td>incumbent</td>
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<tr>
<td>Acting Commissioner of Insurance</td>
<td>Jonathan T. ‘Jon’ Pike</td>
<td>1/5/2021</td>
<td>2/4/2021</td>
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<tr>
<td>Interim Commissioner of Insurance</td>
<td>Tanji J. Northrup</td>
<td>10/1/2020</td>
<td>1/5/2021</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Todd E. Kiser</td>
<td>12/20/2012</td>
<td>9/30/2020</td>
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<td>9</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Neal T. Gooch</td>
<td>5/24/2010</td>
<td>12/20/2012</td>
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<tr>
<td>Acting Commissioner of Insurance</td>
<td>Neal T. Gooch</td>
<td>1/19/2010</td>
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<td>Commissioner of Insurance</td>
<td>D. Kent Michie</td>
<td>1/5/2005</td>
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<td>Commissioner of Insurance</td>
<td>Merwin U. Stewart</td>
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<td>12/31/2004</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Robert E. Wilcox</td>
<td>1/27/1993</td>
<td>2/7/1997</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Harold C. Yancey</td>
<td>7/1/1985</td>
<td>1/27/1993</td>
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### NAIC Member Tenure List

#### UTAH — Continued

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<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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</thead>
<tbody>
<tr>
<td>Commissioner of Insurance</td>
<td>Roger C. Day (Died July 18, 2019)</td>
<td>6/1/1977</td>
<td>7/1/1985</td>
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<td>Commissioner of Insurance</td>
<td>Clifton N. Ottosen</td>
<td>2/1/1965</td>
<td>6/1/1977</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>E. Virgil Norton</td>
<td>1/1/1961</td>
<td>1/30/1965</td>
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<td>Commissioner of Insurance</td>
<td>Lewis M. Terry</td>
<td>5/1/1949</td>
<td>9/11/1953</td>
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<tr>
<td>Acting Commissioner of Insurance</td>
<td>H. J. Timmerman</td>
<td>3/16/1949</td>
<td>5/1/1949</td>
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<td>Commissioner of Insurance</td>
<td>Oscar W. Carlson</td>
<td>9/12/1941</td>
<td>3/16/1949</td>
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<tr>
<td>Acting Commissioner of Insurance</td>
<td>Clifton N. Ottosen</td>
<td>3/15/1941</td>
<td>9/12/1941</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>C. Clarence Nelson</td>
<td>4/1/1937</td>
<td>3/15/1941</td>
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<td>Commissioner of Insurance</td>
<td>Elias A. Smith, Jr.</td>
<td>4/1/1933</td>
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<td>Commissioner of Insurance</td>
<td>John G. McQuarrie</td>
<td>3/13/1925</td>
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<td>Commissioner of Insurance</td>
<td>John W. Walker</td>
<td>4/1/1921</td>
<td>3/13/1925</td>
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<td>Commissioner of Insurance</td>
<td>Rulon S. Wells</td>
<td>3/15/1917</td>
<td>4/1/1921</td>
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<td>Commissioner of Insurance</td>
<td>John James</td>
<td>7/10/1914</td>
<td>3/15/1917</td>
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<td>Commissioner of Insurance</td>
<td>Willard Done</td>
<td>10/10/1910</td>
<td>7/10/1914</td>
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<td>Commissioner of Insurance</td>
<td>George B. Squires (Died Sept. 30, 1910)</td>
<td>4/8/1909</td>
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<tr>
<td>Secretary of State</td>
<td>Charles S. Tingey</td>
<td>1/2/1905</td>
<td>4/3/1909</td>
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<tr>
<td>Secretary of State</td>
<td>James T. Hammond</td>
<td>1/6/1896</td>
<td>1/2/1905</td>
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<tr>
<td>Secretary of Territory</td>
<td>Elijah Sells</td>
<td>5/16/1889</td>
<td>5/6/1893</td>
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<tr>
<td>Secretary of Territory</td>
<td>William C. Hall</td>
<td>4/6/1887</td>
<td>5/16/1889</td>
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<tr>
<td>Secretary of Territory</td>
<td>Arthur L. Thomas</td>
<td>9/1/1884</td>
<td>4/6/1887</td>
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#### VERMONT — Appointed, Biannually by the Governor with Senate Consent

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<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tbody>
<tr>
<td>Commissioner, Department of Financial Regulation (DFR)</td>
<td>Michael S. ‘Mike’ Peciak</td>
<td>7/5/2016</td>
<td></td>
<td>incumbent</td>
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<tr>
<td>Commissioner, DFR</td>
<td>Susan L. Donegan</td>
<td>11/13/2012</td>
<td>6/30/2016</td>
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<tr>
<td>Commissioner, DFR</td>
<td>Stephen W. ‘Steve’ Kimbell</td>
<td>4/4/2012</td>
<td>11/13/2012</td>
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<tr>
<td>Commissioner, Department of Banking, Ins., Securities and Health Care Admin. (BISHCA)</td>
<td>Stephen W. ‘Steve’ Kimbell</td>
<td>1/7/2011</td>
<td>4/3/2012</td>
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<tr>
<td>Commissioner, BISHCA</td>
<td>Michael F. ‘Mike’ Bertrand</td>
<td>6/18/2010</td>
<td>1/7/2011</td>
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<td>Commissioner, BISHCA</td>
<td>Paullette J. Thabault</td>
<td>1/22/2007</td>
<td>6/18/2010</td>
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<tr>
<td>Commissioner, BISHCA</td>
<td>John P. Crowley</td>
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<td>1/5/2007</td>
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<td>Cmsr. of Banking and Insurance</td>
<td>Jeffery P. Johnson</td>
<td>1/13/1990</td>
<td>8/14/1992</td>
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<td>Gretchen Babcock</td>
<td>7/10/1987</td>
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<td>Cmsr. of Banking and Insurance</td>
<td>Thomas P. Menson</td>
<td>3/30/1986</td>
<td>7/1/1987</td>
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<td>Cmsr. of Banking and Insurance</td>
<td>George A. Chaffee</td>
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<td>Cmsr. of Banking and Insurance</td>
<td>Stewart M. Ledbetter</td>
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<td>2/22/1980</td>
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<td>Jean B. Baldwin</td>
<td>6/23/1976</td>
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<td>Cmsr. of Banking and Insurance</td>
<td>James A. Guest</td>
<td>7/16/1973</td>
<td>6/25/1976</td>
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<tr>
<td>Cmsr. of Banking and Insurance</td>
<td>Charles F. Black</td>
<td>1/9/1969</td>
<td>1/3/1973</td>
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<td>James H. Hunt</td>
<td>7/20/1965</td>
<td>1/8/1969</td>
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<td>Cmsr. of Banking and Insurance</td>
<td>Robert E. Cummings, Jr.</td>
<td>6/7/1963</td>
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<td>Cmsr. of Banking and Insurance</td>
<td>Alexander H. Miller</td>
<td>3/1/1951</td>
<td>2/28/1961</td>
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</table>
NAIC MEMBER TENURE LIST

**STATE/MEMBER TITLE** | **MEMBER NAME** | **BEGIN DATE** | **END DATE** | **YRS. SERVED** | **MOS. SERVED**
---|---|---|---|---|---

**VERMONT — Continued**

| Acting Cmsr. of Banking and Ins. | Albert D. Pingree | 11/15/1950 | 3/1/1951 | 0 | 4 |
| Cmsr. of Banking and Insurance | Donald A. Hemenway | 12/1/1947 | 11/15/1950 | 2 | 11 |
| Cmsr. of Banking and Insurance | Charles E. Burns | 7/1/1943 | 12/1/1947 | 4 | 5 |
| Acting Cmsr. of Banking and Ins. | Albert D. Pingree | 4/29/1943 | 7/1/1943 | 0 | 2 |
| Cmsr. of Banking and Insurance | Reginald T. Cole | 2/1/1941 | 4/29/1943 | 2 | 3 |
| Cmsr. of Banking and Insurance | Donald A. Hemenway | 2/1/1937 | 2/1/1941 | 4 | 0 |
| Cmsr. of Banking and Insurance | George B. Carpenter | 8/12/1935 | 2/1/1937 | 1 | 6 |
| Cmsr. of Banking and Insurance | L. Douglas Meredith | 8/1/1934 | 8/12/1935 | 1 | 0 |
| Cmsr. of Banking and Insurance | George H.V. Allen | 5/1/1934 | 8/1/1934 | 0 | 3 |
| Cmsr. of Banking and Insurance | Robert C. Clark | 4/15/1923 | 5/1/1934 | 11 | 1 |
| Insurance Commissioner | Laurence A. Kelty | 10/1/1922 | 4/15/1923 | 0 | 6 |
| Secretary of State | Guy W. Bailey | 10/1/1915 | 4/11/1917 | 1 | 6 |
| State Treasurer | Walter F. Scott | 10/1/1908 | 10/1/1915 | 7 | 0 |
| Secretary of State | Guy W. Bailey | 10/1/1902 | 10/1/1908 | 6 | 0 |
| State Treasurer | Edward H. Deavitt | 10/1/1902 | 10/1/1908 | 6 | 0 |
| Secretary of State | Fred A. Howland | 10/1/1898 | 10/1/1902 | 4 | 0 |
| State Treasurer | John L. Bacon | 10/1/1890 | 10/1/1898 | 8 | 0 |
| Secretary of State | Chauncey W. Browell, Jr. | 10/1/1890 | 10/1/1898 | 8 | 0 |
| State Treasurer | Henry F. Field | 10/1/1890 | 10/1/1898 | 8 | 0 |
| Secretary of State | Charles W. Porter | 10/1/1884 | 10/1/1890 | 6 | 0 |
| State Treasurer | William H. Dubois | 10/1/1884 | 10/1/1890 | 6 | 0 |
| Secretary of State | George Nichols | 10/1/1882 | 10/1/1884 | 2 | 0 |
| State Treasurer | William H. Dubois | 10/1/1882 | 10/1/1884 | 2 | 0 |
| Secretary of State | George Nichols | 9/17/1873 | 10/1/1882 | 9 | 1 |

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

| Lt. Governor/Ins. Commissioner | Tregenza A. Roach (Elected Nov. 20, 2018) | 1/7/2019 | incumbent |
| Lt. Governor/Ins. Commissioner | Osbert E. Potter | 1/5/2015 | 1/7/2019 | 3 | 11 |
| Lt. Governor/Ins. Commissioner | Gregory R. Francis | 1/1/2007 | 1/5/2015 | 8 | 0 |
| Lt. Governor/Ins. Commissioner | Vargrave A. Richards | 1/6/2003 | 1/1/2007 | 4 | 0 |
| Director, Banking & Insurance | Gwendolyn 'Gwen' Hall Brady | 5/1/1996 | 5/1/1998 | 2 | 0 |
| Director, Banking & Insurance | Larry Diehl | 1/2/1995 | 2/12/1995 | 1 | 1 |
| Lt. Governor/Ins. Commissioner | Derek M. Hodge | 1/5/1987 | 1/2/1995 | 8 | 0 |
| Lt. Governor/Ins. Commissioner | Juan Francisco Luis | 1/6/1975 | 1/2/1978 | 3 | 0 |
| Govt. Secretary/Ins. Commissioner | Cyril E. King | 5/1/1961 | 9/30/1969 | 8 | 4 |
### NAIC MEMBER TENURE LIST

#### VIRGIN ISLANDS — Continued

<table>
<thead>
<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tbody>
<tr>
<td>Govt. Secretary/Ins. Commissioner</td>
<td>Position Vacant</td>
<td>5/31/1957</td>
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#### VIRGINIA — Appointed, at the Pleasure of the State Corporation Commission

<table>
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<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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#### WASHINGTON — Elected; 4-Year Term

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#### WEST VIRGINIA — Appointed, at the Pleasure of the Governor

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

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<td>Jeffrey ‘Jeff’ Rude</td>
<td>6/19/2019</td>
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<td>Insurance Commissioner</td>
<td>Thomas C. ‘Tom’ Hirsig</td>
<td>4/16/2012</td>
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<td>Insurance Commissioner</td>
<td>Kenneth G. ‘Ken’ Vines</td>
<td>2/21/2003</td>
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<td>Gordon W. Taylor, Jr.</td>
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<td>Ben S. Murphy</td>
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<td>Vincent J. Horn, Jr.</td>
<td>6/1/1970</td>
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<td>Mark Duncan</td>
<td>6/1/1963</td>
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<td>Gilbert A.D. Hart</td>
<td>5/1/1960</td>
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<td>Robert Adams</td>
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<td>Insurance Commissioner</td>
<td>Ford S. Taft</td>
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<td>Rodney Barrus</td>
<td>3/18/1945</td>
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<td>Insurance Commissioner</td>
<td>Alex MacDonald</td>
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<td>Insurance Commissioner</td>
<td>Arthur J. Ham</td>
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<td>Insurance Commissioner</td>
<td>Theodore Thulemeyer</td>
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<td>Insurance Commissioner</td>
<td>Lyle E. Jay</td>
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### WYOMING—Continued

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<td>John M. Fairfield</td>
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<td>Insurance Commissioner</td>
<td>Harry A. Loucks</td>
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<td>Robert B. Forsyth</td>
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"Updated: 4/5/2021"

W:\Pubs\_Commissioner\Tenure\_Tenure_List_Master.docx
The following is a record of officers and list of national meeting locations at which the N AIC has met since its organization.

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<tr>
<th>Mtg</th>
<th>M/D/Y</th>
<th>Meeting Site</th>
<th>President</th>
<th>Vice-President</th>
<th>Secretary</th>
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<td>5/24-6/2/1871</td>
<td>New York, NY</td>
<td>George W. Miller, NY</td>
<td>Llewelyn Breese, WI</td>
<td>Henry S. Olcott, NY</td>
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<td>10/18-30/1871</td>
<td>New York, NY</td>
<td>George W. Miller, NY</td>
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<td>Henry S. Olcott, NY</td>
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<td>10/12-1872</td>
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<td>9/17-20/1873</td>
<td>Boston, MA</td>
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<td>Orlow W. Chapman, NY</td>
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<td>9/26-27/1883</td>
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<td>Madison, WI</td>
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<td>Orsamus R. Fyler, CT</td>
<td>Jacob A. McEwen, OH</td>
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<td>George B. Luper, PA</td>
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<td>John J. Brinkerhoff, IL</td>
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<td>Stephen W. Carr, ME3</td>
<td>Frederick L. ‘Fred’ Cutting, MA</td>
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<td>Old Point Comfort, VA</td>
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<td>William A. Fricke, WI</td>
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<td>Harry R. Cunningham, MT</td>
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<td>Fritz Hugh McMaster, SC</td>
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<td>1st James R. Young, NC</td>
<td>Fritz Hugh McMaster, SC</td>
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<td>1st Willard Done, UT11</td>
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<td>John S. Darst, WV</td>
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<td>2nd John S. Darst, WV</td>
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<td>2nd John T. Winship, MI</td>
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<td>Denver, CO</td>
<td>Michael J. Cleary, WI12</td>
<td>2nd Emory H. English, IA</td>
<td>1st Robert J. Merrill, NH12</td>
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<td>2nd Walter K. Chorn, MO12</td>
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<td>Alfred L. Harty, MO15</td>
<td>2nd Frank H. Ellsworth, MI</td>
<td>2nd Joseph L. Button, VA</td>
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<td>Swampscott, MA</td>
<td>Thomas B. Donaldson, PA</td>
<td>1st Thomas B. Donaldson, PA15</td>
<td>2nd Joseph L. Button, VA</td>
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© 2021 National Association of Insurance Commissioners
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<th>M/D/Y</th>
<th>Meeting Site</th>
<th>President</th>
<th>Vice-President</th>
<th>Secretary</th>
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<td>8/1923</td>
<td>Minneapolis, MN</td>
<td>Herbert O. Fishback, WA</td>
<td>1st John C. Luning, FL</td>
<td>Joseph L. Button, VA</td>
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<td>John C. Luning, FL</td>
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<td>Harry L. Conn, OH</td>
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<td>Cincinnati, OH</td>
<td>Albert S. Caldwell, TN</td>
<td>1st Samuel W. McCulloch, PA</td>
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<td>9/1928</td>
<td>Rapid City, SD</td>
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<td>9/1929</td>
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<td>Howard P. Dunham, CT</td>
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<td>Jess G. Read, OK</td>
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<td>Dallas, TX</td>
<td>Charles D. Livingston, MI</td>
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<td>Chicago, IL</td>
<td>Garfield W. Brown, MN</td>
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<td>Garfield W. Brown, MN</td>
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<td>Quebec, Canada</td>
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<td>San Francisco, CA</td>
<td>Frank N. Julian, AL</td>
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<td>Joseph L. Button, VA</td>
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<td>John Sharp Williams III, MS</td>
<td>Charles F. J. Harrington, MA</td>
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<td>Ralph F. Apodaca, NM</td>
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<td>Lee I. Kueckelhan, WA</td>
<td>Cyrus E. Magnusson, MN</td>
<td>Ralph F. Apodaca, NM</td>
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M/D/Y

Meeting Site

President

Vice-President

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New Orleans, LA
Cleveland, OH
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Phoenix, AZ
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Detroit, MI
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Tampa, FL
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Wilmington, DE
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Baltimore, MD
Kansas City, MO
Louisville, KY

Cyrus E. Magnusson, MN
Cyrus E. Magnusson, MN
William E. Timmons, IA
William E. Timmons, IA
Frank J. Barrett, NE
Frank J. Barrett, NE
James L. Bentley, GA
James L. Bentley, GA
Charles R. Howell, NJ31
Ned Price, TX
Ned Price, TX
Ned Price, TX

William E. Timmons, IA
William E. Timmons, IA
Frank J. Barrett, NE
Frank J. Barrett, NE
James L. Bentley, GA
James L. Bentley, GA
Charles R. Howell, NJ
Charles R. Howell, NJ
Ned Price, TX
Richard E. ‘Dick’ Stewart, NY
Richard E. ‘Dick’ Stewart, NY
Richard E. ‘Dick’ Stewart, NY
Lorne R. Worthington, IA
Richards D. ‘Dick’ Barger, CA
Russell E. Van Hooser, MI
Russell E. Van Hooser, MI
W. Fletcher Bell, KS
W. Fletcher Bell, KS
Johnnie L. Caldwell, GA
Johnnie L. Caldwell, GA
Kenneth E. ‘Ken’ DeShetler, OH34
Richard L. ‘Dick’ Rottman, NV
Richard L. ‘Dick’ Rottman, NV
Lester L. Rawls, OR
Lester L. Rawls, OR
Harold B. McGuffey, KY
Harold B. McGuffey, KY
H. Peter ‘Pete’ Hudson, IN
H. Peter ‘Pete’ Hudson, IN
Wesley J. Kinder, CA
Wesley J. Kinder, CA
William H. L. Woodyard III, AR
William H. L. Woodyard III, AR
John W. Lindsay, SC36
Johnnie L. Caldwell, GA36
Roger C. Day, UT
Roger C. Day, UT
Roger C. Day, UT
William D. ‘Bill’ Gunter, FL
William D. ‘Bill’ Gunter, FL
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William D. ‘Bill’ Gunter, FL
Bruce W. Foudree, IA
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Bruce W. Foudree, IA
Josephine M. Driscoll, OR
Josephine M. Driscoll, OR
Josephine M. Driscoll, OR
Josephine M. Driscoll, OR
Edward J. Muhl, MD
Edward J. Muhl, MD
Edward J. Muhl, MD
Edward J. Muhl, MD
John E. Washburn, IL
John E. Washburn, IL
John E. Washburn, IL
John E. Washburn, IL
David A. Gates, NV
David A. Gates, NV
David A. Gates, NV
David A. Gates, NV
Earl R. Pomeroy, ND
Earl R. Pomeroy, ND
Earl R. Pomeroy, ND
Earl R. Pomeroy, ND
James E. ‘Jim’ Long, NC
James E. ‘Jim’ Long, NC
James E. ‘Jim’ Long, NC
James E. ‘Jim’ Long, NC

Richard E. ‘Dick’ Stewart, NY32

Lorne Worthington, IA
Richards D. ‘Dick’ Barger, CA
Richards D. ‘Dick’ Barger, CA
Russell E. Van Hooser, MI
Russell E. Van Hooser, MI
W. Fletcher Bell, KS
W. Fletcher Bell, KS
Johnnie L. Caldwell, GA33
William H. Huff III, IA34
William H. Huff III, IA
Richard L. ‘Dick’ Rottman, NV
Richard L. ‘Dick’ Rottman, NV
Lester L. Rawls, OR
Lester L. Rawls, OR
Harold B. McGuffey, KY
Harold B. McGuffey, KY
H. Peter ‘Pete’ Hudson, IN
H. Peter ‘Pete’ Hudson, IN35
Wesley J. Kinder, CA
Wesley J. Kinder, CA
William H. L. Woodyard, AR
William H. L. Woodyard, AR
Lyndon L. Olson Jr., TX
Lyndon L. Olson Jr., TX
Lyndon L. Olson Jr., TX
Roger C. Day, UT
Roger C. Day, UT
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Roger C. Day, UT
William D. ‘Bill’ Gunter, FL
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Bruce W. Foudree, IA
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Josephine M. ‘Jo’ Driscoll, OR
Josephine M. ‘Jo’ Driscoll, OR
Josephine M. ‘Jo’ Driscoll, OR
Josephine M. ‘Jo’ Driscoll, OR
Edward J. Muhl, MD
Edward J. Muhl, MD
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Edward J. Muhl, MD
John E. Washburn, IL
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John E. Washburn, IL
David A. Gates, NV
David A. Gates, NV
David A. Gates, NV
David A. Gates, NV
Earl R. Pomeroy, ND
Earl R. Pomeroy, ND
Earl R. Pomeroy, ND
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Ralph F. Apodaca, NM
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<td>Therese M. ‘Terri’ Vaughn, IA</td>
<td>J. Michael ‘Mike’ Pickens, AR</td>
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1. Sept. 23, 1886: John K. Tarbox (MA) was elected President for the 1887 Convention; Samuel H. Cross (RI) was elected Vice-President; and Robert B. Brinkerhoff (Ohio chief clerk) was elected Secretary. Commissioner Tarbox died May 28, 1887. Auditor Cross was out of office effective June 1, 1887. Mr. Brinkerhoff was out of office effective May 3, 1887. Oliver Pillsbury (NH) was chosen to preside over the 1887 Convention. It is unknown who acted as Vice-President. Jacob A. McEwen (Ohio chief clerk) was chosen to act as Secretary.

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

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

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

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

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

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

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

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

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

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

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

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

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

16. Sept. 8, 1922: Platt Whitman (WI) was elected President for the 1923 Convention; Herbert O. Fishback (WA) was elected First Vice-President; and John C. Luning (FL) was elected Second Vice-President. July 1, 1923: Commissioner Whitman resigned as President; Commissioner Fishback was elected President for the 1923 Convention by the Executive (EX) Committee; and Mr. Luning was elected First Vice-President by the Executive (EX) Committee. It is unknown who acted as Second Vice-President.

17. Sept. 18, 1925: William R. C. Kendrick (IA) was elected President for the 1926 Convention. January 1926: Commissioner Kendrick resigned as NAIC President and Harry L. Conn (OH) was elected President for the 1926 Convention. Commissioner Kendrick remained as Iowa Insurance Commissioner until March 1, 1926.
18. Nov. 19, 1926: Harry L. Conn (OH) was elected President for the 1927 Convention and Albert S. Caldwell (TN) was elected First Vice-President. April 15, 1927: Superintendent Conn resigned as NAIC President and Ohio Insurance Superintendent. May 3, 1927: Commissioner Caldwell was elected President for the 1927 Convention and James A. Beha (NY) was elected First Vice-President.

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

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

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

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

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

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

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

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

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

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

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

30. June 1962: Joseph S. Gerber (IL) was elected Vice-President; however, he resigned effective Jan. 29, 1963, as NAIC Vice-President and Illinois Insurance Director. The office of Vice-President was vacant for the June 1963 Convention.

31. June 1968: Charles R. Howell (NJ) was elected President; however, he resigned effective Feb. 28, 1969, as NAIC President and New Jersey Commissioner of Banking and Insurance. Ned Price (TX) was elected by the Executive (EX) Committee to fill the unexpired term.

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

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

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

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

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

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

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

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

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

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

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


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

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

47. David C. Mattax, NAIC Secretary-Treasurer and Texas Insurance Commissioner, died in office April 13, 2017. A special Plenary interim election was held via conference call on May 12, 2017: South Carolina Insurance Director Raymond G. Farmer was elected Secretary-Treasurer to serve from May 12, 2017, to Dec. 31, 2017.
48. Gordon I. Ito resigned effective Dec. 31, 2018, as NAIC Vice President and Hawaii Insurance Commissioner. A special Plenary interim election was held in La Quinta, California, on Feb. 4, 2019: Florida Insurance Commissioner David Altmaier was elected Vice President to serve from Feb. 4, 2019, to Dec. 31, 2019.

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

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

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

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

*Updated: 4/5/2021*
NAIC Model Laws, Regulations and Guidelines

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

**Annual Financial Reporting Model Regulation (#205)**
10-172, 10-173, 10-174, 10-219, 10-220, 10-221

**Annuity Disclosure Model Regulation (#245)**
2-2, 2-6, 3-3, 3-4, 4-19, 6-3, 6-4

**Antifraud Plan Guideline (#1690)**
2-1, 2-13, 3-1, 3-7, 3-90, 3-91, 3-98, 3-99, 3-100, 9-3, 9-56

**Corporate Governance Annual Disclosure Model Act (#305)**
9-48

**Corporate Governance Annual Disclosure Model Regulation (#306)**
9-48

**Credit for Reinsurance Model Law (#785)**
2-22, 3-5, 3-23, 3-24, 3-32, 3-33, 3-106, 10-15, 10-174, 10-221, 10-885, 10-962, 10-964, 10-965, 10-969, 10-970, 10-971, 10-975, 10-980, 10-984, 10-986, 10-996, 11-18, 11-23, 11-28, 11-33

**Credit for Reinsurance Model Regulation (#786)**
2-22, 3-106, 10-15, 10-885, 10-962, 10-964, 10-965, 10-969, 10-970, 10-971, 10-975, 10-980, 10-983, 10-984, 10-985, 10-986, 10-997, 11-18, 11-28, 11-33

**Creditor-Placed Insurance Model Act (#375)**
3-5, 3-23, 3-24, 3-32, 3-33

**Financial Guaranty Insurance Guideline (#1626)**
10-368

**Guideline for Administration of Large Deductible Policies in Receivership (#1980)**
2-1, 3-1, 3-8, 3-101

**Guideline for Definition of Reciprocal State in Receivership Laws (proposed)**
2-16, 2-21, 3-7, 10-1, 10-2, 10-3, 10-75, 10-76, 10-77, 10-857, 10-858, 10-859, 10-961

**Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts (#1556)**
10-854

**Health Benefit Plan Network Access and Adequacy Model Act (#74)**
7-22

**Health Carrier Prescription Drug Benefit Management Model Act (#22)**
4-20, 7-22

**Health Information Privacy Model Act (#55)**
9-5, 9-52

**Health Insurance Reserves Model Regulation (#10)**
11-32

**Health Maintenance Organization Model Act (#430)**
3-105, 9-48, 9-49

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Insurance Data Security Model Law (#668)
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CALL TO ORDER

The 231st session of the National Association of Insurance Commissioners (NAIC) will now come to order. Good morning, my name is David Altmaier. I’m Florida’s Commissioner and President of the NAIC; and I’m honored to open the first national meeting of the year.

INTRODUCTION OF HEAD TABLE

To start us off, I’d like to introduce the members of our virtual head table.

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

Please welcome the members of our NAIC Spring National Meeting virtual head table. I would also like to recognize our new members in this short video. [New Member Video Plays]

PRESIDENTIAL ADDRESS

Welcome to the 2021 Spring National Meeting of the National Association of Insurance Commissioners. It is an honor to welcome you this year as NAIC president. I know many of us continue to respond to the COVID-19 pandemic, and I want to thank you for your ongoing commitment to our mission of supporting state insurance regulators and ensuring that consumer protection keeps pace with our changing markets. This is our fourth virtual national meeting; and while this is no substitute for getting to meet with one another face to face, I know we will continue to make great strides towards all we are looking to accomplish this year and moving forward. The NAIC provides a framework for incredible collaboration across our 56 states and territories, and we are truly a member-driven organization.

Our workstreams, task forces, and national meetings like this bring together a broad spectrum of viewpoints and encourage discourse crucial to supporting our state-based system of insurance regulation. 2021 marks the 150th anniversary of the NAIC. Not many organizations can claim this milestone, and this longevity is a testament to the leadership provided by our membership and the dedicated NAIC employees who serve them.

On May 24, 1871, the NAIC held its first meeting. Twenty state delegates met for nine days to develop a plan for interstate insurance regulation serving the public good and building a strong foundation for the future of the insurance industry. Some of the leading underwriters of the day asserted that the founding of the NAIC and the collaboration it encouraged would probably do more to help American consumers understand the insurance market than anything the United States had yet seen. While NAIC founders assuredly did not meet via WebEx, the intent of their meeting is not so different from our meeting today. Gather regulators and stakeholders from around the country to discuss important issues and collaborate on ways to best serve the insurance consumers in their states.

Our history provides us with valuable lessons as we move forward. As the 2020 pandemic hit, we went back to our archive from the 1918 pandemic to see what regulators at the time had documented, what action they had taken to navigate unprecedented challenges, and how they protected consumers. While none of us know what the future holds, our work today will serve as a guidepost for future generations. Our thoughts, decisions and actions will provide valuable insight for those we represent now and for those who will follow in our footsteps. Those two fundamental traits, collaboration and coordination, have served us well and allowed us to adapt and evolve our regulation and the protection of consumers to the world around us. Throughout the NAIC’s history, we have seen that when tested, we have not just persevered, but we have adapted, improved, and come out as a stronger system. It is a system that has been tested by two World Wars, the Great Depression, the Great Depression, the Great Depression, the Great Depression, the Great Depression, the Great Depression, the Great Depression, the Great Depression.
Recession, two pandemics, and countless other challenges; and our system remains strong and resilient. The NAIC’s success lies in its member driven approach. The unique backgrounds, experiences and perspectives of our members in service to our common mission are central to the NAIC’s ability to adapt to a changing marketplace. Throughout our 150-year history, we have demonstrated that we can anticipate and absorb change, shift priorities, and work through numerous challenges to strengthen our collective efforts. As you look at our history, a pattern emerges. We are tested by the events of the day, and we respond, coming out the other side of the challenge stronger than before. In 1968, a subcommittee was formed to establish and study the applicability of data processing techniques. The Michigan Insurance Department developed a computer program, along with Michigan State University, to assist in the auditing of annual statements. This program proved successful and was transitioned to the NAIC, allowing insurers to input data into a single location accessible to all regulators. By 1974, the NAIC was working to develop early warning systems for solvency monitoring and developed capabilities for its database. By 1978, the NAIC had established itself as a trusted source for industry data. Today, the NAIC holds one of the most robust financial data repositories in the world. The NAIC membership came together to adopt financial regulation standards and in 1990 established the accreditation program. The strength of the system resides in the interdependence of state regulators and the corresponding need for a credible and robust state-based system focused on consumer protection and strong solvency oversight. I have seen these advancements firsthand. Following the financial crisis of 2008, the NAIC and state insurance regulators embarked on the Solvency Modernization Initiative (SMI), which included a review of international developments that would inform and influence the next decade of our work. The Solvency Modernization Initiative focused on enhancements to capital requirements, governance and risk management, group supervision, statutory accounting and financial reporting and reinsurance requirements, among other facets. The financial crisis, also led to a redoubling of the NAIC’s coordination and outreach with federal agencies, Congress and international counterparts to ensure our actions informed and were informed by global developments. Later in 2016, as it became clear life insurance beneficiaries were too often unaware of the benefits they were owed, NAIC members developed the life insurance policy locator, helping reunite beneficiaries with more than $1 billion in unclaimed benefits since its inception. These are important milestones, but represent only a small fraction of what we have done and what we will do through the NAIC. While it's challenging to encapsulate 150 years of accomplishments into a short speech, I would like to take a few minutes to share a short video looking at NAIC’s rich history. [NAIC 150th Anniversary Video Plays]

The past has taught us we can never take our eyes off the road ahead. Our past informs our present here at the NAIC, as well as our plans for the future. So let me turn now from our past to our present and future. I am proud to lead the dedicated members of the NAIC during this historic year, and I’m pleased to share some of our upcoming celebrations around the NAIC’s 150th anniversary. For the past several years, as we looked at the brands in anticipation of our 150th anniversary, it seems like an ideal time to explore other options and improve the performance of the overall look and feel of the NAIC for our members, our consumers and our industry. Working with our membership that NAIC has developed a new logo. In thinking about what makes the unique, we understood the success of our organization is due to the commitment of our members and how they work together to serve the public good. So, we worked on creating a logo which emphasizes the commissioner’s collaboration protecting consumers. I'm pleased to unveil our new logo for you now. [NAIC Logo Video Plays]

Embedded in that simple, intertwined "C" is all of our DNA from that first meeting. Our commissioners, their collaboration, the community they have created, and the consumers they protect. Our logo will be rolled out starting today. In the coming weeks, you will see revisions to our website and other documents that reflect who we are, but now let's look ahead to 2021 and the actions we are taking as part of our 150-year commitment to consumers and the insurance sector. We have some challenging work ahead of us this year. The NAIC and its members highlight its priorities annually. We determine what the priorities are during the first quarter of each year. Focus areas support the core mission of protecting consumers and safeguarding markets.

As you know, priorities can change quickly, especially with a major event like the pandemic. In 2020, the NAIC had a set of priorities in place, but it quickly pivoted to focus on COVID-19. Understandably, COVID-19 continues to be a topic we are intensely focused on. The pandemic challenged us throughout 2020, and while the vaccines offer hope that there is an end in sight, there is still much work to be done as vaccines roll out to create widespread immunity. We will continue to make sure policyholders have access to affordable testing and treatment and engage with the administration, Congress and federal agencies regarding ongoing COVID-19 recovery efforts. As court challenges continue over business interruption insurance coverage, the NAIC remains steadfast in its commitment to work with Congress and offer guidance around solutions for a federal mechanism to help ensure widespread availability of business interruption insurance for pandemic risks. For a more detailed account of the extraordinary efforts made by state insurance regulators and the NAIC throughout 2020, you can access three reports chronicling our efforts at www.naic.org.

In 2021, we will continue our focus on natural catastrophes and climate risk. We have focused on natural catastrophes for many years. The NAIC added climate risk to its charge in February 2005 at the annual commissioners’ conference. The Climate Change and Global Warming Task Force met for the first time at the 2006 Summer National Meeting and began working on a white paper released in 2008 titled "The Potential Impact of Climate Change on Insurance Regulation." In 2010, the insurer
Climate Risk Disclosure Survey was adopted. In 2020, we formed the Climate and Resiliency Task Force, which reports directly to the Executive Committee, a move signaling our increased engagement and commitment to this initiative. Task Force members are considering appropriate climate disclosures within the insurance sector; evaluating financial regulatory approaches; investigating innovative insurer solutions to climate risk and resiliency; and identifying sustainability, resilience and mitigation issues related to the insurance industry. The Climate Task Force began holding weekly calls in January 2021 to gain information and perspectives around the NAIC Climate Risk Disclosure Survey and other climate disclosures. This was done with the goal of developing recommendations to address who should report, what will be reported, and how data will be collected and used in the future. The NAIC is committed to engaging, protecting, educating and advocating for our consumers in the face of the historic challenges posed by climate risk. Once again, as we have in the past, we will rise to meet this challenge.

We will also continue our work on the critical issue of race and insurance. Over the years, the NAIC has tackled several issues related to bias and discrimination in the insurance sector. The first version of the Unfair Trade Practices Act was adopted by the NAIC in 1947. The act defines and prohibits unfair discrimination for life, health, property and casualty insurance. The act also prohibits, among other things, the refusal to insure, refusal to renew, and cancelation or limitation of coverage amounts because of sex, marital status, race, religion or national origin of the individual. In 1978, the NAIC issued a report making policy recommendations to address problems facing inner city homeowners who are having trouble securing adequate insurance due to the legacy of redlining. In the 1990s, state insurance departments aggressively pursued companies using zip codes or redlining as an early form of proxy discrimination, targeting mostly urban areas. The NAIC also worked to dismantle race-based premiums for life insurance. In 2000, NAIC members signed a resolution encouraging state regulators to investigate whether life insurers were charging black customers more than white customers for certain life policies. Last year, our members formed a Special Executive Committee to continue to address issues related to race and insurance, including a commitment to diversity, equity and inclusion (DE&I) within the NAIC and across the insurance industry. The response from our membership was tremendous, with almost all NAIC members joining the committee. In February this year, the NAIC shared its internal diversity, equity and inclusion framework, which is built on four pillars: the workforce, the workplace, its members and the community. The NAIC’s employees and leadership developed this framework collaboratively to drive change, promote accountability in the workplace, and offer the insurance sector a model to build similar programs. The NAIC will continue to lead by example in the areas of DE&I. Through the NAIC, the commissioners conducted research and held public forums to foster understanding and address concerns from within the insurance industry, consumer representatives and other interested parties. Our listen and learn efforts have given us much to consider as we develop a plan of short- and long-term initiatives. We are currently reviewing research and commentary to evaluate steps we can take to eliminate practices or barriers which potentially disadvantage people of color or historically underrepresented groups. To have so many members and stakeholders join the discussion will only further our efforts of having a diverse, inclusive member-led discussion. There are still a lot of work ahead as we strive to eliminate unfair discrimination, whether intentional or unintentional, within the insurance sector. We know this is a journey that will take continual effort, but we are up to the task.

Another focus area this year is big data and consumer data privacy. The insurance industry has always been data driven. The speed by which data is being utilized by both regulatory and insurance-focused functions was hastened by the pandemic. From online applications to accelerated underwriting, the immense amount of available public data is growing. Commissioners must not only stay up to date on current technology, but regulators must also understand how emerging technology may impact insurance consumers and the sector both positively and negatively. They must also ensure consumer data is protected, as we have seen an escalation in breaches across several sectors. The implications of big data and artificial intelligence, as well as consumer privacy, protection and cybersecurity, remain important issues for us in 2021 and beyond. Last year, the membership adopted the AI principles. These principles inform and articulate general expectations for businesses, professionals and stakeholders across the insurance industry. As we implement AI tools, these principles will serve as critical guideposts for any members. We will continue to engage in appropriate and informed regulation of big data driven insurance practices. The Innovation and Technology Task Force continues to research developments related to big data and algorithmic modeling and risk management practices, with the goal of releasing a report at the Fall National Meeting. Technological advancements, AI, and consumer data privacy protections cut across a wide range of activities and work groups. Our members will continue to engage with each other, state attorneys general, Congress, and federal and international agencies to share best practices and insights around the implementation of emerging technology while protecting the privacy and rights of the public we serve. State insurance regulators interact with their federal counterparts on a regular basis on cybersecurity matters. Director Farmer represents the NAIC on the Financial and Banking Information Infrastructure Committee, which is charged with coordinating efforts to improve the security and reliability of the infrastructure for financial markets. The NAIC participates in FBICIC calls with Treasury, Federal and state financial regulators and the Cybersecurity and Infrastructure Security Agency to share information around cyber activity. In addition to cyber information sharing, Treasury, state insurance regulators and the NAIC have collaborated to facilitate several tabletop exercises with insurers to explore cyber incidents, response and recovery. These exercises help regulators and the insurance industry test their ability to respond effectively to potential incidents. The NAIC is
committed to continuing to coordinate future exercises with additional state insurance departments, industry, and federal and state law enforcement officials.

Long-term care insurance (LTCI) also remains a focus. State insurance regulators have been grappling with the issue of LTCI for many years. This includes issues surrounding a shrinking market, the threat of current and future insolvencies, and the impact of large rate increases on our most vulnerable residents. As part of the initiatives around long-term care (LTC), the Long-Term Care Insurance (EX) Task Force was formed last year with commissioner level involvement to help determine the path forward. As a result of the hard work of the members in these groups, we have seen tangible progress towards the goals of the Task Force, including improved analysis of companies’ reserves, a pilot program for a uniform and efficient multi-state rate review process, and a principles document regarding reduced benefit options. We will continue ongoing efforts to improve the consistency around LTC rate review processes and remain focused on the consumer. We want to ensure that consumers are able to understand these increases and the available mitigation options so that they can choose the option that best aligns with their needs while maintaining affordability.

In addition to advancing our policy priorities, our members are overseeing the implementation of State Ahead and the development of our State Ahead 2.0 plan. State Ahead is NAIC’s the strategic blueprint for the future of our state system. Some highlights of this initiative include enhanced tools for state insurance departments, improved actuarial modeling resources, enhanced financial analysis tools, improved data modeling capabilities, and updated consumer resources. The goal of State Ahead remains to provide our members with the tools, talent and technology they need to ensure the U.S.’s ongoing preeminence as the largest single insurance market. Later this year, NAIC members will get together and build the strategy for State Ahead 2.0.

And like most things at the NAIC, we are not building this just for ourselves, but for the generations of regulators to come. As we imagine the future of insurance, I am sure that the NAIC will be at the forefront of progress and continue its legacy for years to come. The insurance market of 150 years ago doesn't look much like the market of today, but as we always have, we will continue to adapt and forecast what the insurance sector may look like five, 25, 50 or another 150 years from now. Today's priorities may be COVID-19, natural catastrophe and climate, race and insurance, AI, big data, consumer data, privacy protection, and LTC. but rest assured; while we have an eye on the issues of today, the members of the NAIC are constantly scanning forward to see what may be in the future to ensure this rich 150-year legacy will continue for another 150 years. We will, as we have been from the very beginning, be guided by our commitment to each other and the consumers we protect.

I want to thank those of you participating in this virtual Spring National Meeting. This is an important avenue for supporting our unique state-based system of insurance. I believe that as regulators, we make our best decisions when we consider as many different perspectives on issues as we can so that the decisions we ultimately make are as informed as they can possibly be. This is a member driven effort, and communication with one another and open discussions with stakeholders are vital to our consumer protection efforts. There are a number of important sessions in the days ahead, and I encourage you to engage as much as possible. At the end of the day, we can make consumer driven and data driven decisions that promote solid and stable markets for consumers to rely on. I look forward to working and connecting with each of you.

ADJOURNMENT

David Altmaier, NAIC President

My door is always open, and with that, I officially conclude this opening session of the 231st meeting of the National Association of Insurance Commissioners.
Synopsis of the NAIC Committee, Subcommittee and Task Force Meetings
Virtual 2021 Spring National Meeting
April 7–14, 2021

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

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

EXECUTIVE (EX) COMMITTEE AND PLENARY (Joint Session)
April 14, 2021
1. Adopted the report of the Executive (EX) Committee. See the Committee listing for details.
2. Adopted by consent the committee, subcommittee and task force minutes of the 2020 Fall National Meeting.
4. Received the report of the Life Insurance and Annuities (A) Committee. See the Committee listing for details.
5. Received the report of the Health Insurance and Managed Care (B) Committee. See the Committee listing for details.
6. Received the report of the Property and Casualty Insurance (C) Committee. See the Committee listing for details.
7. Received the report of the Market Regulation and Consumer Affairs (D) Committee. See the Committee listing for details.
8. Received the report of the Financial Condition (E) Committee. See the Committee listing for details.
9. Received the report of the Financial Regulation Standards and Accreditation (F) Committee. See the Committee listing for details.
10. Received the report of the Real Property Lender-Placed Insurance Model Act (#631).
15. Received a status report on state implementation of NAIC-adopted model laws and regulations.

EXECUTIVE (EX) COMMITTEE
April 14, 2021
1. Adopted the report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, which met April 7 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee and Subcommittee took the following action:
   A. Adopted its March 16, 2021; Feb. 24, 2021; and 2020 Fall National Meeting minutes.
   B. Adopted the report of the Audit Committee, which met April 1 and took the following action:
      2. Received the 2020 audit report from RSM.
      3. Received an update on the 2020/2021 Service Organization Control (SOC) 1 and SOC 2 reviews.
   C. Adopted the report of the Information Systems (EX1) Task Force, which met March 24 and took following action:
      1. Adopted its 2020 Fall National Meeting minutes.
      2. Received an update on the 2021 NAIC System for Electronic Rate and Form Filing (SERFF) fiscal.
      3. Received an operational report on the NAIC’s information technology (IT) activities.
   D. Approved the exposure of the Solvency Workpaper Software Modernization – Implementation Preparation Phase fiscal for public comment.
   E. Approved the NAIC SERFF Modernization – Mobilization and Pilot Phase fiscal.
   F. Approved the State Based Systems (SBS) State Implementations 2021 fiscal.
   G. Approved the Property/Casualty (P/C) Rate Model Review Staffing Resources fiscal.
   H. Received a joint chief executive officer (CEO)/chief operating officer (COO) report.
   I. Discussed the development of the State Ahead 2.0 strategic plan.
2. Adopted the report of the Executive (EX) Committee, which met March 16 and Feb. 24 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During these meetings, the Committee took the following action:
   A. Adopted the March 3 minutes of the Internal Administration (EX1) Subcommittee, including investment reports and recommendations on the NAIC’s long-term investment portfolio.
   B. Approved next steps for the Long-Term Care Insurance (LTCI) Legal Restructuring fiscal, which includes:
      1. Defer action by the Executive (EX) Committee until further deliberation can be completed.
   C. Approved the exposure of the SERFF Modernization – Mobilization and Pilot Phase fiscal for public comment.
   D. Approved the SBS State Implementations 2021 fiscal for public comment.
   E. Approved the exposure of the P/C Rate Model Review Staffing Resources fiscal for public comment.
   F. Appointed Commissioner Sharon P. Clark (KY) to serve on the National Insurance Producer Registry (NIPR) Board of Directors, effective April 9.
   G. Received an update on 2020 year-end financial results.
   H. Reviewed the NAIC Conflict of Interest Policy.
   I. Approved moving the Financial Stability (EX) Task Force from the Executive (EX) Committee to the Financial Condition (E) Committee.
   J. Approved the following non-regulator appointments to the SERFF Advisory Board: Birny Birnbaum (Center for Economic Justice—CEJ) as the consumer representative; Andrea Davey (Athena Annuity and Life Company) as a life insurance representative and vice chair; Phyllis Hollerbach (Zurich North America) as a health insurance representative; and Susan Gould (The Hanover Insurance Group) as a P/C representative.
   K. Appointed the following NAIC members to serve on the 2021 NAIC/Consumer Participation Board of Trustees: Commissioner Michael Conway (CO) as chair; Director Chlora Lindley-Myers (MO) as vice chair; Commissioner John F. King (GA); Commissioner Marlene Caride (NJ); Superintendent Russell Toal (NM); and Commissioner Jessica K. Altman (PA).
   L. Reappointed the following consumer representatives to serve on the 2021 NAIC/Consumer Participation Board of Trustees: Amy Bach (United Policyholders—UP); Brendan Bridgeland (Center for Insurance Research—CIR); Bonnie Burns (California Health Advocates); Brenda J. Cude (University of Georgia); Katie Keith (Out2Enroll); and Sarah Lueck (Center on Budget and Policy Priorities—CBPP).
   M. Approved an amendment to the NAIC Grant and Zone Fund Policy.
   N. Heard an update on NAIC cybersecurity.
   O. Selected Las Vegas, NV, as the site of the 2025 Fall National Meeting.

3. Adopted the report of the Climate and Resiliency (EX) Task Force. See the Task Force listing for details.
5. Adopted the report of the Innovation and Technology (EX) Task Force. See the Task Force listing for details.
6. Adopted the report of the Long-Term Care Insurance (EX) Task Force. See the Task Force listing for details.
7. Adopted 2021 charges for the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force.
8. Adopted the report of the Special (EX) Committee on Race and Insurance. See the Special Committee listing for details.
10. Received the 2020 annual report of the NAIC Designation Program Advisory Board.
11. Received a status report on implementation of the NAIC State Ahead strategic plan.
12. Received a status report on model law development efforts for amendments to: the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171); the Annuity Disclosure Model Regulation (#245); the Life Insurance Disclosure Model Regulation (#580); the Unfair Trade Practices Act (#880); the Insurance Holding Company System Regulatory Act (#440); the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450); and new models, including the Real Property Lender-Placed Insurance Model Act, the Pet Insurance Model Act, and the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act.
13. Heard reports from NIPR and the Interstate Insurance Product Regulation Commission (Compact).

**Climate and Resiliency (EX) Task Force**

April 9, 2021

1. Adopted its 2020 Fall National Meeting minutes.
2. Received reports from its workstreams, which included the following action:
   A. Solvency Workstream: Reviewed the NAIC Capital Markets Bureau response to the International Association of Insurance Supervisors (IAIS) Global Insurance Market Report (GIMAR) data call, which will be published by the IAIS in June, and sent a referral to the Catastrophe Risk (E) Subgroup to consider adding more perils to the risk-based capital (RBC) charge.
   B. Innovation Workstream: Heard presentations regarding parametric insurance to fill coverage gaps for natural disasters.
   C. Technology Workstream: Heard a presentation from the NAIC Center for Insurance Policy and Research (CIPR) and Risk Management Services (RMS) regarding an application paper that shows how mitigation activities can reduce the risk of wildfire.

3. Received a recommendation from the Climate Risk Disclosure Workstream to continue using the existing framework whereby insurers may file either the NAIC Climate Risk Disclosure Survey or a report based on the Task Force on Climate-related Financial Disclosures (TCFD) for 2021. The workstream will continue its review of modifications to the climate risk disclosure to align with the TCFD and promote uniformity in reporting requirements.

4. Heard a presentation on the Building Code and Mitigation Workshop developed under the Pre-Disaster Mitigation Workstream in coordination with the CIPR and the Federal Alliance for Safe Homes (FLASH).

5. Heard a presentation on NAIC climate-related communications activities, including a consumer survey and an update of the home inventory mobile application.

6. Heard an update on federal activities related to climate risk.

7. Heard an update on international activities related to climate risk.

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

Innovation and Technology (EX) Task Force
April 9, 2021

1. Adopted its 2020 Fall National Meeting minutes.

2. Adopted the report of the Big Data and Artificial Intelligence (EX) Working Group, including its March 29 minutes. During this meeting, the Working Group took the following action:
   A. Reviewed its 2021 charges and discussed why the former Big Data (EX) Working Group and the former Artificial Intelligence (EX) Working Group were merged into one group.
   B. Discussed developing an industry survey to research how insurance companies are using big data, algorithms and artificial intelligence (AI).
   C. Heard a presentation on the development and components of a model governance framework.

3. Adopted the report of the Speed to Market (EX) Working Group, including its Nov. 10, 2020, minutes. During this meeting, the Working Group took the following action:
   A. Heard an update from the Interstate Insurance Product Regulation Commission (Compact).
   B. Discussed the results of the Product Requirements Locator (PRL) survey and next steps.
   C. Received updates on the NAIC System for Electronic Rate and Form Filing (SERFF), including recent and upcoming releases and projects, and discussed the annual review of the product coding matrix (PCM) and uniform transmittal document (UTD) suggestions.

4. Discussed follow-up comments related to the request for information (RFI) responses on continuing specific “regulatory relief” or “regulatory accommodations” offered by states or necessary related to the COVID-19 pandemic. The Task Force took the following action:
   A. Adopted a motion to appoint a working group to: 1) examine e-commerce laws and regulations; 2) survey the states regarding federal Uniform Electronic Transactions Act (UETA) exceptions; 3) work toward meaningful, unified recommendations; 4) examine whether a model bulletin would be appropriate for addressing some of the identified issues; and 5) draft a proposed bulletin, if determined appropriate.
   B. Referred identified issues related to allowing online processes to be used for producer licensing continuing education (CE) to the Producer Licensing (D) Task Force and referred surplus lines issues—such as home state taxation, insurer eligibility, exempt commercial purchaser and diligent search—to the Surplus Lines (C) Task Force because it falls within its current workstream to amend the Nonadmitted Insurance Model Act (#870).
   C. Heard a report on the activities of the NAIC Innovation and Technology State Contacts group. The group met April 1 and discussed an insurer’s perspective on the open Insurance Data Link (openIDL) solution for improving state
insurance regulators’ access to data, parametric insurance products, and possible upcoming presentations from InsurTechs.

5. Heard presentations from State Farm and the United States Automobile Association (USAA) on their auto subrogation blockchain solution; Trellis Connect on its digital data-sharing application for personal lines of property/casualty (P/C) insurance; and Vero on its online risk and insurance advisor tool offering automated advice to help agents and individuals based on AI.

6. Received updates from the Special (EX) Committee on Race and Insurance, the Accelerated Underwriting (A) Working Group, the Property and Casualty Insurance (C) Committee, and the Privacy Protections (D) Working Group regarding their work on workstreams related to innovation and technology to ensure coordination of these activities.

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

**April 9, 2021**

1. Adopted its March 1, 2021, and 2020 Fall National Meeting minutes, which included the following action:
   A. Adopted 2021 proposed charges for the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup.

2. Received the report of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, which met March 9 and Feb. 25 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings, to discuss the process for drafting the multistate rate review framework and form a drafting group.

3. Exposed the operational sections of the draft long-term care insurance (LTCI) multistate rate review framework for a 45-day public comment period ending May 24.

4. Received the report of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup, which met March 24 and March 11 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings, to discuss plans for addressing its 2021 charges. The Subgroup plans to meet in early May to begin work on its charges by discussing current innovative long-term care (LTC) wellness pilot programs and seeking stakeholder views of related regulatory issues that need to be addressed.

5. Heard a report on industry trends that could have an impact on the solvency of LTCI companies and factors affecting reserves.


7. Heard an update on the LTCI special data call. The Task Force continues to work with the consulting firm to develop a public report of the results.

**Special (EX) Committee on Race and Insurance**

**April 12, 2021**

1. Heard a report on its activities, including:
   A. Established five workstreams to develop initial recommendations.
   B. Met April 6 and March 24 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings, to receive the workstreams’ initial recommendations and to determine where to place the continued work in the NAIC committee structure.

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

3. Heard comments from interested parties on its 2021 proposed charges.

4. Exposed its 2021 proposed charges for a 30-day public comment period ending May 14.
INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE
See the Executive (EX) Committee listing for details.

Information Systems (EX1) Task Force
March 24, 2021 (in lieu of the Spring National Meeting)
1. Adopted its Nov. 20, 2020, minutes.
2. Received an update on the 2021 NAIC System for Electronic Rate and Form Filing (SERFF) fiscal.
3. Received an operational report on the NAIC’s information technology (IT) activities. The report provides updates for upcoming improvements, impacts to new state technology offerings from the NAIC, and general updates on the activities of the NAIC technology team.
4. Received a project portfolio update, including project status reports for 22 active technical projects and a summary of five projects recently completed.
5. Adjourned into regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings.

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE
April 12, 2021
1. Adopted its 2020 Fall National Meeting minutes.
2. Adopted the report of the Life Actuarial (A) Task Force. See the Task Force listing for details.
3. Adopted the report of the Accelerated Underwriting (A) Working Group, including its March 19 minutes. During this meeting, the Working Group took the following action:
   A. Heard an update from the ad hoc drafting group regarding progress made in drafting an educational report on accelerated underwriting in life insurance, which included the following plans:
      1. Meet every three weeks to maintain progress in drafting language to share with the Working Group.
      2. Work from the Nov. 16, 2020, outline distributed during the Nov. 17, 2020, Working Group meeting.
      3. Focus the draft narrowly to remain consistent with and avoid conflicts with the work of other NAIC groups, such as the Innovation and Technology (EX) Task Force, the Big Data and Artificial Intelligence (EX) Working Group, the Casualty Actuarial and Statistical (C) Task Force, and the Privacy Protections (D) Working Group.
      4. Share draft language with the Working Group and interested parties for comment as sections are completed.
4. Adopted the report of the Annuity Suitability (A) Working Group, including its March 25 and March 9 minutes. During these meetings, the Working Group took the following action:
   A. Adopted its Feb. 22 minutes, which included the following action:
      1. Discussed potential revisions to the draft frequently asked questions (FAQ) guidance document.
   B. Adopted its Dec. 14, 2020, minutes, which included the following action:
      1. Discussed the comments received by the Oct. 2, 2020, public comment deadline on the draft FAQ guidance document the Working Group is developing to assist the states with adoption and implementation of the revised Suitability in Annuity Transactions Model Regulation (#275), which added a best interest standard of conduct for insurers and producers.
   C. Continued its discussion of potential revisions to the FAQ guidance document and directed NAIC staff to revise the document based on the discussions to date and distribute the revised document for the Working Group’s discussion and possible adoption during a meeting in late April or early May.
5. Adopted the report of the Life Insurance Illustration Issues (A) Working Group, including its March 10 and Feb. 23 minutes. During these meetings, the Working Group took the following action:
   A. Continued making progress in the development of a one- to two-page consumer-oriented policy overview document in order to achieve its charge of improving the understandability of the life insurance policy summaries already required in Section 7B of the Life Insurance Illustrations Model Regulation (#582) and Section 5A(2) of the Life Insurance Disclosure Model Regulation (#580).
   B. Revised two alternative draft versions of the sample policy overview for term life policies based on comments received during a public comment period ending Aug. 28, 2020. One version shows the sample pre-underwriting; the other, after underwriting.
   C. Planned to consider during its next meeting a motion to bring revised versions of the policy overview and corresponding revised versions of Model #580 to the Committee for guidance to the Working Group on next steps.
6. Adopted an extension of the Request for NAIC Model Law Development requested by the Life Insurance Illustration Issues (A) Working Group to allow the Working Group to make agreed-upon revisions, so the Committee can have sufficient information to provide guidance to the Working Group on next steps.

7. Heard an update on the Special (EX) Committee on Race and Insurance Workstream Four. The primary conclusion of Workstream Four, which was reflected in the proposed Special Committee charges, was that it had only just started to delve into the practices and barriers that potentially disadvantage minority and underserved populations in the life insurance and annuities line of business.

8. Discussed and adopted modifications to its 2021 charges, specifically:
   A. Adopted a motion to disband the Annuity Disclosure (A) Working Group once the Executive (EX) Committee and Plenary consider adoption of the participating income annuity revisions to the Annuity Disclosure Model Regulation (#245), which were adopted and then held by the Life Insurance and Annuities (A) Committee at the 2018 Summer National Meeting.
   B. Disbanded the Retirement Security (A) Working Group, which has fulfilled its charge.

9. Discussed life insurer practices related to the COVID-19 pandemic:
   A. Heard from the Consumer Federation of America (CFA) regarding its letter requesting that the NAIC develop a model rule for life insurance underwriters who may delay or deny coverage for people who have or have had COVID-19.
   B. Heard from the Interstate Insurance Product Regulation Commission (Compact) regarding life insurance application questions related to COVID-19 and COVID-19 vaccinations.
   C. Discussed social media misinformation that COVID-19 vaccinations will affect policyholders’ life insurance benefits, which it will not.

Life Actuarial (A) Task Force
April 8, 2021
1. Adopted its March 18, 2021; March 11, 2021; March 4, 2021; Feb. 25, 2021; Feb. 11, 2021; Feb. 4, 2021; Jan. 28, 2021; Jan. 21, 2021; and Dec. 17, 2020, minutes, which included the following action:
   A. Adopted its 2020 Fall National Meeting minutes.
   B. Discussed amendment proposal 2021-02, which would extend the use of the 2020 nonforfeiture rates through June 2022, instead of through December 2021. After discussion, the amendment proposal was withdrawn.
   C. Discussed questions received on the economic scenario generator (ESG).
   D. Heard an update on the ESG project.
   E. Heard a presentation from Conning on the equity model.
   F. Heard an overview of ESG documents that were exposed for a public comment period ending March 22. The comment period for all previous ESG exposures was also extended to March 22.
   G. Adopted amendment proposal 2020-11.
   H. Discussed amendment proposal 2019-33.
   I. Exposed amendment proposal 2020-12 for a 50-day public comment period ending March 26.
   K. Discussed comments on the “Criteria to Assess VM-20 Solutions for Modeling Non-guaranteed YTR Reinsurance.”
   L. Heard an update on recent changes to Internal Revenue Code (IRC) Section 7702 that replaces the hard-coded 4% rate for the cash value accumulation test and the 6% rate used in the net single premium calculation for the guideline premium test with an indexed rate.
   M. Exposed the ESG scenario statistics and reports, the Scenario Picker Tool, and the Stochastic Exclusion Ratio Test (SERT) documents for a 45-day public comment period ending March 7.
   N. Exposed a spreadsheet summarizing the decisions needed for the Treasury, equity and corporate models and a spreadsheet showing the parameters of the Treasury model for a public comment period ending Jan. 31.
2. Adopted the report of the Experience Reporting (A) Subgroup, including its March 2 minutes. During this meeting, the Subgroup took the following action:
   A. Received an update on the mortality experience data collection project. There are plans to start developing mandatory reporting of variable annuity data and to continue work on evaluating actuarial aspects of accelerated underwriting in 2021.
3. Adopted the report of the Guaranteed Issue (GI) Life Valuation (A) Subgroup, which has not met since the 2020 Fall National Meeting. The Subgroup is in a dormant/monitoring mode given that there have been no new known studies of GI life mortality that could prove useful in formulating a new prescriptive requirement for the reserves for GI life products.
4. Adopted the report of the Indexed Universal Life (IUL) Illustration (A) Subgroup, which has not met since the 2020 Fall National Meeting. The Subgroup plans to meet again after any significant market developments following the adoption of Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest Sold on or After November 25, 2020 (AG 49-A).

5. Adopted the report of the Longevity Risk (E/A) Subgroup, which has not met since the 2020 Fall National Meeting. A drafting group has been formed to contemplate reserve requirements related to pension risk transfer (PRT) and longevity reinsurance (LR) transactions that are more specific to the PRT reserves and are not solely related to the longevity component. The Subgroup will reconsider C-2 risk-based capital (RBC) for PRT products or LR transactions after reviewing the drafting group’s recommendations for the resolution of identified issues.

6. Adopted the report of the Variable Annuities Capital and Reserve (E/A) Subgroup, which has not met since the 2020 Fall National Meeting. The Subgroup will monitor the results of companies implementing the Variable Annuity Framework and stands ready to consider any requests of the Task Force or the Life Risk-Based Capital (E) Working Group.

7. Adopted the report of the Valuation Manual (VM) -22 (A) Subgroup, including its March 17, March 3, Feb. 24, Feb. 10, Feb. 3, Jan. 27 and Jan. 20 minutes. During these meetings, the Subgroup took the following action:
   A. Voted to use two risk categories for VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, valuations.
   B. Tabled a motion to retain the language in Section 5A of VM-20, Requirements for Principle-Based Reserves for Life Products, that allows for the aggregation of products with significantly different risk profiles if the products are managed as part of an integrated risk-management process.
   C. Voted to retain the SERT language in Section 6A of VM-20.
   D. Discussed the timing of the VM-22 field test, which is scheduled for February 2022 through June 2022.
   E. Discussed the preliminary framework elements for fixed annuity principle-based reserving (PBR) proposed by the American Academy of Actuaries (Academy).
   F. Formed a PRT drafting group to look at issues surrounding PRT business.

8. Exposed amendment proposal 2020-10 for a 45-day public comment period ending May 25.

9. Discussed and provided a response to comments on the ESG.

10. Heard an update from the Society of Actuaries (SOA) on research and education.

11. Heard an update from the Academy Life Practice Council.


13. Exposed amendment proposal 2021-04 for a 21-day public comment period ending April 28.

14. Exposed amendment proposal 2021-03 for a 25-day public comment period ending May 3.

15. Re-exposed amendment proposal 2020-12 for a 21-day public comment period ending April 28.

16. Heard an update from NAIC staff on the mortality data collection project.

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

**April 12, 2021**

1. Adopted its 2020 Fall National Meeting minutes.

2. Heard a presentation from the Biden administration on its federal legislative and administrative initiatives and priorities. The presentation included a discussion of the future of the health insurance marketplaces, which highlighted the sharp decrease in the uninsured after 2010, followed by an increase since 2016, and how minority rates of the uninsured were persistently higher in 2019 than for non-minorities. Enrollment in the marketplaces has steadied, and insurer participation in the marketplaces has improved, but premium cost remains a challenge. The presentation discussed how the federal American Rescue Plan Act of 2021 (ARPA) could address some of the marketplace premium cost issues. The presentation also provided updates on the number of individuals that have enrolled to date in the marketplaces using the current special enrollment period, which has been extended to Aug. 31. The presentation also touched on the consumer protections regarding surprise bills included in the recently enacted federal No Surprises Act (NSA). The Biden administration’s actions to address the COVID-19 pandemic under the federal Families First Coronavirus Response Act (FFCRA) and the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act was also discussed.

3. Adopted the report of the Consumer Information (B) Subgroup, including its April 1 minutes. During this meeting, the Subgroup took the following action:
   A. Discussed potential topics for the Subgroup to address in 2021, such as the ARPA, the claims process, and the NSA.
   B. Discussed potential products for the Subgroup to develop in 2021, such as a series of briefs on claims, updating the “Frequently Asked Questions on Health Care Reform” (FAQ document), and developing new products related to the NSA and the ARPA.
4. Adopted the report of the Health Innovations (B) Working Group, including its March 26 minutes. During this meeting, the Working Group took the following action:
   A. Heard presentations on telehealth coverage issues from the Center for Connected Health Policy (CCHP), the American Psychiatric Association (APA), and Regence.
   B. Heard a presentation from Washington regarding changes to its provider network review policies resulting from a greater demand for telehealth services during the COVID-19 pandemic.
   C. Discussed the effects of increased premium tax credit payments on federal funding for state reinsurance programs.
5. Adopted the report of the Health Actuarial (B) Task Force. See the Task Force listing for details.
6. Adopted revised 2021 charges for the Health Actuarial (B) Task Force.
7. Adopted the report of the Regulatory Framework (B) Task Force. See the Task Force listing for details.
8. Received the draft [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM Model Act). The Committee plans to meet following the Spring National Meeting to discuss the proposed PBM Model Act and determine its next steps.
9. Adopted the report of the Senior Issues (B) Task Force. See the Task Force listing for details.
10. Heard an update on the work of the Special (EX) Committee on Race and Insurance Workstream Five related to its charge to examine and determine which practices or barriers exist in the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups in the health insurance line of business and make recommendations on actions steps. The Workstream adopted an initial report March 23 and forwarded its recommendations to the Special Committee for consideration.
11. Heard a discussion of the Committee’s subgroup, working group and task force planned work for 2021.

Health Actuarial (B) Task Force
The Health Actuarial (B) Task Force did not meet at the Spring National Meeting.

Regulatory Framework (B) Task Force
March 25, 2021 (in lieu of the Spring National Meeting)
1. Adopted its March 18, 2021; March 1, 2021; and 2020 Fall National Meeting minutes, which included the following action:
   A. Adopted the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM Model Act).
   B. Discussed comments received on the draft PBM Model Act.
2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, which has not met since December 2019 due to the COVID-19 public health emergency and the resignation of one of its co-chairs. Due to the recent appointment of a new co-chair, it is anticipated that the Subgroup will resume its meetings in late April.
3. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group, which has not met since the 2020 Fall National Meeting. It is anticipated that the Working Group will likely next meet sometime following the Spring National Meeting to discuss any updates regarding association health plans (AHPs), including the status of the appeal in State of New York et al. v. U.S. Department of Labor et al. The Working Group also could discuss the U.S. Supreme Court’s decision in Rutledge v. Pharmaceutical Care Management Association with respect to any ERISA preemption issues. It then plans to adjourn into regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.
4. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its Jan. 28 minutes. During this meeting, the Working Group heard presentations from stakeholders—consumers, providers and plans—on their experiences with the implementation of and compliance with the MHPAEA’s mental health parity requirements. The Working Group also met March 10 in regulator-to-regulator session, pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.
5. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, which has not met since October 2020 because it completed its work. The Subgroup could resume meeting to start work on a new 2021 charge to develop a white paper on issues related to the state regulation of certain pharmacy benefit manager (PBM) business practices.
6. Heard an update from the Center on Health Insurance Reforms (CHIR) on its work related to federal Affordable Care Act (ACA) implementation; recently enacted federal laws, such as the federal No Surprises Act (NSA) and the federal American Rescue Plan Act of 2021 (ARPA); and other issues of interest to state insurance regulators. The update included a discussion of the CHIR’s efforts to assess the impact of the extended special enrollment periods (SEPs) into the federal health insurance exchanges, as provided in the ARPA, on access and affordability of coverage and how it will be
implemented. The CHIR is continuing its work to track state regulatory reforms affecting the individual market, such as the ACA Section 1332 waiver program, including whether the states are looking at other options, in addition to reinsurance programs, in light of the ARPA that could positively affect the affordability of comprehensive coverage. The CHIR is also continuing its work of tracking state regulatory approaches to the COVID-19 pandemic. The presentation also highlighted some of the CHIR’s future work on network adequacy, standardized health plans, and non-comprehensive coverage arrangements.

7. Heard a presentation on the NSA. The presentation highlighted the NSA’s scope, including what types of plans it covers and where its protections apply. The NSA does not apply to short-term plans and excepted benefits plans. It also does not apply to ground ambulance services, but it does apply to air ambulance services. The presentation described how the NSA protects patients from balance bills by requiring that patients be held responsible for in-network cost sharing only and barring providers from sending or collecting a bill for amounts other than in-network cost sharing. The presentation also discussed a key component of the NSA; i.e., determining the payment amount for out-of-network care when there is a payment dispute. The presentation highlighted the NSA’s enforcement mechanisms and the role that the states will have. Lastly, the presentation discussed what questions remain with the NSA with respect to states that currently have balance billing laws and those that do not. The presentation also discussed next steps regarding the NSA, including the anticipated federal regulations.

8. Heard a discussion of the U.S. Supreme Court’s decision in Rutledge v. Pharmaceutical Care Management Association and its potential effect on the ability of state insurance regulators to regulate certain PBM business practices. The Task Force anticipates more discussion of the case as part of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s future work to develop a white paper on state options with respect to regulating PBM business practices and the ERISA (B) Working Group’s discussion of the case’s potential impact with respect to ERISA preemption.

Senior Issues (B) Task Force
Feb. 23, 2021 (in lieu of the Spring National Meeting)
1. Discussed its 2021 agenda heard comments from interested parties regarding suggested topics to address.
2. Agreed that the Long-Term Care Insurance Model Update (B) Subgroup should begin its work.

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE
April 13, 2021
1. Adopted its 2020 Summer National Meeting and 2020 Fall National Meeting minutes.
2. Adopted the report of the Casualty Actuarial and Statistical (C) Task Force. See the Task Force listing for details.
3. Adopted the report of the Surplus Lines (C) Task Force. See the Task Force listing for details.
4. Adopted the report of the Title Insurance (C) Task Force. See the Task Force listing for details.
5. Adopted the report of the Workers’ Compensation (C) Task Force. See the Task Force listing for details.
6. Adopted the report of the Cannabis Insurance (C) Working Group, including its March 11 minutes. During this meeting, the Working Group took the following action:
   A. Discussed its 2021 work plan, which includes:
      1. Consider drafting a memorandum to the Government Relations (EX) Leadership Council to consider if the NAIC should take a position on the federal Secure and Fair Enforcement (SAFE) Banking Act of 2019.
      2. Consider drafting a memorandum to the Government Relations (EX) Leadership Council asking that it study the status of issues related to the U.S. Department of Justice (DOJ) “Cole” memorandum.
      3. Hold a fact-finding hearing to hear from insurance companies on barriers they experience in expanding coverage availability in this space. Develop a report on the findings.
      4. Consider drafting a memorandum to the Producer Licensing (D) Task Force asking that it examine how cannabis-related convictions may be preventing licensing approvals.
   B. Adopted its Nov. 17, 2020, minutes.
   C. Heard federal updates regarding the National Flood Insurance Program (NFIP) and the U.S. Department of Housing and Urban Development (HUD) proposed rule to change Federal Housing Administration (FHA) regulations to allow lenders to accept private flood insurance policies on FHA-insured properties located in Special Flood Hazard Areas (SFHAs).
   D. Heard a presentation regarding a product that runs storm surge and wind velocity models prior to a storm making landfall. The product provides data down to the individual address that is geocoded with a latitude and longitude.
   E. Heard presentations from Alabama, California, Louisiana, Mississippi and Texas regarding recent catastrophic events.
8. Adopted the report of the Pet Insurance (C) Working Group, including its April 8 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its March 26 minutes, which included the following action:
      1. Adopted its March 4 minutes, which included the following action:
         a. Adopted its Feb. 18 minutes, which included the following action:
            1. Discussed Section 7 and Section 8 of the draft Pet Insurance Model Act
            2. Discussed Section 3D of the draft Pet Insurance Model Act.
            3. Discussed policy renewals as they relate to the draft Pet Insurance Model Act.
            4. Discussed unresolved issues within the draft Pet Insurance Model Act.
   9. Adopted the report of the Terrorism Insurance Implementation (C) Working Group, which has not met since the 2020 Fall National Meeting.
10. Adopted the report of the Transparency and Readability of Consumer Information (C) Working Group, including its March 15 minutes. During this meeting, the Working Group:
   A. Adopted its Feb. 4, 2021, and Nov. 17, 2020, minutes, which included the following action:
      1. Discussed the need for consumer disclosures regarding significant premium increases on property/casualty (P/C) products.
      2. Discussed a work plan for drafting a best practices document regarding significant premium increases on P/C products.
   B. Finalized drafting group assignments to begin drafting a best practices document regarding significant premium increases on P/C products and discussed the topics each drafting group was responsible for drafting.
12. Heard an update on recent workshops related to disaster preparedness and response, including roundtables held with the Federal Emergency Management Agency (FEMA).
13. Appointed an NAIC/FEMA Advisory Group with the following charge: The NAIC/FEMA Advisory Group will assist state insurance regulators in engaging and collaborating with FEMA on an ongoing basis by establishing a process for the oversight, prioritization and reporting of disaster-related regional workshops and other exercises to improve disaster preparation and resilience.
14. Heard a presentation related to insurance rating for dog breeds, including a request for state insurance regulators to collect additional rating data and not allow the use of dangerous dog breed lists.
15. Discussed the status of proposed charges related to P/C insurance issues being developed by the Special (EX) Committee on Race and Insurance.

Casualty Actuarial and Statistical (C) Task Force
March 9, 2021 (in lieu of the Spring National Meeting)
1. Adopted its Feb. 17, 2021; Feb. 9, 2021; Feb. 2, 2021; Dec. 30, 2020; and 2020 Fall National Meeting minutes, which included the following action:
   B. Adopted the report of the Actuarial Opinion (C) Working Group.
   C. Adopted the report of the Statistical Data (C) Working Group.
   D. Discussed Ref #2019-49: Retroactive Reinsurance Exception, as referred by the Statutory Accounting Principles (E) Working Group.
   E. Discussed the Casualty Actuarial Society (CAS) decision to rescind the three Statement of Principles related to ratemaking, reserving and valuation.
2. Reported that it met Feb. 16 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss rate filing issues.
4. Adopted the report of the Statistical Data (C) Working Group.
5. Adopted a letter to the CAS in opposition of the CAS’s rescission of its Statement of Principles Regarding Property and Casualty Insurance Ratemaking.
6. Received a report on NAIC rate model reviews. In 2019, with existing actuarial, legal and information technology (IT) staff, the NAIC: a) drafted a contractual agreement, called the Rate Review Support Services Agreement (Agreement), to be used so a state can gain access to a shared model database and can request a rate model technical review from the NAIC; b) developed the initial NAIC rate model technical review process with a consulting actuary; and c) created a shared model database for confidential regulatory communication. Twenty-eight states have contracted with the NAIC using the Agreement and, to date, the NAIC has reviewed 31 rate filings and objection responses for nine states.

7. Heard reports from professional actuarial associations.

Surplus Lines (C) Task Force
The Surplus Lines (C) Task Force did not meet at the Spring National Meeting.

Title Insurance (C) Task Force
March 16, 2021 (in lieu of the Spring National Meeting)
1. Adopted its Feb. 23 minutes, which included the following action:
   A. Adopted its Oct. 21, 2020, minutes.
   B. Discussed its 2021 work plan.
   C. Heard the first part of a presentation on the effects of the COVID-19 pandemic on the title insurance industry.
2. Discussed its revised 2021 work plan, which included:
   A. Exploring the effects of the COVID-19 pandemic on the title insurance industry through presentations.
   B. Revising the title insurance consumer shopping tool template, How to Buy Title Insurance in [Insert State], through member drafting sessions beginning March 23. Nine states are participating in the drafting sessions.
   C. Monitoring issues and developments occurring in the title insurance industry, including profitability and claims settlement.
   D. Assisting the Antifraud (D) Task Force in combating fraud through joint calls and meetings.
   E. Consulting with the Consumer Financial Protection Bureau (CFPB) through regulator-to-regulator calls.
   F. Determining the role of the Task Force in exploring race and insurance implications in the title insurance space.
3. Heard the second part of a presentation on the effects of the COVID-19 pandemic on the title insurance industry.
4. Discussed comments received on proposed revisions to the title insurance consumer shopping tool template, How to Buy Title Insurance in [Insert State].

Workers’ Compensation (C) Task Force
March 15, 2021 (in lieu of the Spring National Meeting)
1. Adopted its 2020 Fall National Meeting minutes.
2. Heard a presentation from the International Association of Industrial Accident Boards and Commissions (IAIABC) regarding data it has been collecting on COVID-19 workers’ compensation claims. The basic measures that have been collected include the number of claims received each year, the number of fatalities, the denial rates, and the rates per 100,000 workers in those claims. This data reported on was taken from the first reports of injury filed in 19 states.
3. Heard a presentation from the National Council on Compensation Insurance (NCCI) regarding the COVID-19 pandemic. The presentation included information on workers’ compensation presumptions regarding compensability for employees affected by COVID-19, combined ratios, COVID-19 loss summaries, and other legislative issues being introduced this year.

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE
April 13, 2021
1. Adopted its 2020 Fall National Meeting minutes.
3. Adopted revisions to the four market analysis chapters of the Market Regulation Handbook.
4. Adopted a 14-day limitation on MCAS filing extension requests.
5. Adopted a requirement for companies to identify MCAS filing attesters by both line of business and by state. This will be implemented for the 2021 data to be reported in 2022.
6. Heard a presentation on lead generators and improper marketing of health insurance. These issues have been monitored by a broad consortium of state insurance regulators with expertise in antifraud, market conduct and health insurance. The Antifraud (D) Task Force will discuss potential next steps on this issue, which could include the appointment of a new working group with new charges under the Antifraud (D) Task Force.
7. Adopted the report of the Antifraud (D) Task Force. See the Task Force listing for details.
9. Adopted the report of the Producer Licensing (D) Task Force. See the Task Force listing for details.
10. Adopted the report of the Market Conduct Annual Statement Blanks (D) Working Group, including its March 23 minutes.
   During this meeting, the Working Group took the following action:
   A. Adopted its Feb. 24 minutes, which included the following action:
      1. Adopted its Nov. 16, 2020, minutes.
      2. Heard an update on the travel MCAS.
      3. Heard an update on the other health MCAS.
      4. Discussed a new MCAS proposal submission form.
      5. Discussed the reporting of complaint and lawsuit data elements within the home and auto MCAS reporting blanks.
      6. Discussed the MCAS lawsuit definitions.
      7. Discussed the addition of accelerated underwriting data elements to the life MCAS and digital claims data elements to the home and auto MCAS lines of business.
   B. Heard an update on the travel MCAS. The subject-matter expert (SME) group has met to discuss the definitions; the group’s next meeting is April 19.
   C. Heard an update on the other health MCAS. The SME group is focusing on short-term limited-duration (STLD) insurance products, and it plans to vote on the STLD blank and definitions prior to June 1. Work on other health products will begin after the STLD work is complete.
   D. Heard an update on the accelerated underwriting and digital claims MCAS discussions. The next SME group meetings for accelerated underwriting and digital claims MCAS will be held April 15.
   E. Discussed the placement of complaint and lawsuit data elements within the home and auto MCAS reporting blanks. The Working Group will continue this discussion during its April 28 meeting.
   F. Discussed the MCAS lawsuit definitions. The Working Group will continue this discussion during its April 28 meeting.
   G. Reported that an updated version of the MCAS proposal submission form has been posted to the Working Group’s web page.
   H. Adopted a motion to add a note in the disability income MCAS blank clarifying that Schedule 3 is designed to only collect claims information about claims that have payment.
11. Adopted the report of the Market Conduct Examination Guidelines (D) Working Group, including its March 30 minutes.
   During this meeting, the Working Group took the following action:
   A. Reviewed its 2021 charges.
   B. Discussed its potential tasks for 2021.
   C. Discussed new title insurance standardized data requests (SDRs) to address in force policies and claims for inclusion in the reference documents of the Market Regulation Handbook.
12. Adopted the report of the Market Analysis Procedures (D) Working Group, including its March 19 minutes. During this meeting, the Task Force took the following action:
   A. Adopted its Feb. 25 minutes, which included the following action:
      1. Adopted its Jan. 27 minutes, which included the following action:
         a. Adopted its Nov. 12, 2020, minutes.
         b. Discussed revisions to the MCAS Best Practices Guide.
         c. Discussed a 14-day limitation for MCAS extension requests.
         d. Discussed the MCAS attestation process.
         e. Heard an update on the small group reviewing and drafting updates to the Market Regulation Handbook chapters on market analysis.
         f. Discussed training opportunities for market regulation analysts.
      2. Discussed revisions to the MCAS Best Practices Guide.
      3. Discussed a 14-day limitation for MCAS extension requests.
      4. Discussed the MCAS attestation process.
      5. Reported that the small group reviewing and drafting updates to the Market Regulation Handbook chapters on market analysis had completed its work. The proposed revisions were exposed for a public comment period ending March 17.
      6. Discussed training opportunities for market regulation analysts.
   B. Adopted revisions to the MCAS Best Practices Guide, which included:
      1. Identify additional best practices and highlighting them in an appendix.
      2. Recommend a 14-day extension limitation.
      3. Reflect changes since the MCAS Best Practices Guide was created in 2014.
C. Adopted a 14-day limitation on MCAS filing extension requests. The MCAS filing submission tool will only allow extensions up to 14 calendar days, but it will allow multiple extension requests if additional time is required. This requires a re-coding of the submission tool. Implementation will be no earlier than 2021 data filed in 2022.

D. Adopted a proposal to change the MCAS filing blanks to require companies to identify MCAS filing attesters by both line of business and by state. This change should be implemented for the 2021 data year reported in 2022.

E. Adopted revisions to the four market analysis chapters of the Market Regulation Handbook. The revisions updated the market analysis chapters to reflect changes since the last revisions of the chapters.

F. Discussed market analysis training suggestions and opportunities.

G. Reported that NAIC staff will submit a Uniform System Enhancement Request (USER) form to the Market Information Systems Research and Development (D) Working Group in response to a notification from the industry about the file size limitation when uploading filings into the MCAS.

13. Adopted the report of the Privacy Protections (D) Working Group, including its March 29 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its 2020 Fall National Meeting minutes.
   B. Received NAIC status reports on federal and state privacy legislation.
   C. Reviewed the 2021 NAIC member-adopted strategy for consumer data privacy protections.
   D. Discussed comments received on 2020 Fall National Meeting verbal gap analysis.
   E. Announced the consumer privacy protections panel for the virtual NAIC Insurance Summit in June.

Antifraud (D) Task Force

March 24, 2021 (in lieu of the Spring National Meeting)

1. Adopted its Nov. 16, 2020, minutes.
2. Received the report of the Antifraud Education Enhancement (D) Working Group. The Working Group held a webinar on Feb. 11 from CARCO regarding the mobile capabilities it can provide state insurance departments to assist with fighting insurance fraud. The Working Group will be holding an investigator safety training on June 2.
3. Received the report of the Antifraud Technology (D) Working Group. The Working Group noted that the revision of Antifraud Plan Guideline (#1690) was the first step in its charge to “review and provide recommendations for the development of an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions.” The Working Group’s next step is to build a template for the industry to use when creating their antifraud plans. Once the template is finalized, the Working Group will work with NAIC staff to finalize recommendations for the Antifraud Plan Repository.
4. Discussed its 2021 charges, including the monitoring of insurance fraud related to the COVID-19 pandemic. The Task Force will continue to monitor the insurance fraud trends generated by the COVID-19 pandemic and to bring general awareness to the states, the industry and the public about possible threats.
5. Received an update on the NAIC Online Fraud Reporting System (OFRS) redesign project. The NAIC is continuing its work on the redesign of the OFRS, with beta testing on schedule to begin in April.
6. Heard reports on antifraud activity from NAIC staff, as well as the National Insurance Crime Bureau (NICB) and the Coalition Against Insurance Fraud (CAIF).

Market Information Systems (D) Task Force

March 22, 2021 (in lieu of the Spring National Meeting)

1. Adopted its 2020 Fall National Meeting minutes.
2. Reviewed its 2021 charges and assigned the charge to “develop recommendations for the incorporation of artificial intelligence (AI) abilities in NAIC Market Information Systems (MIS) for use in market analysis” to the Market Information Systems Research and Development (D) Working Group.
3. Adopted the report of the Market Information System Research and Development (D) Working Group, which met March 10 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings. During this meeting, the Working Group took the following action:
   A. Adopted proposed changes to the coding structure of the NAIC Regulatory Information Retrieval System (RIRS). The proposal will be exposed on the Task Force web page.
   B. Reviewed the MIS data analysis metrics and recommendations.
   C. Adopted changes to the Uniform System Enhancement Request (USER) process reflecting the agile approach used by the NAIC.
D. Discussed how to proceed with the charge to develop recommendations for the incorporation of AI abilities in the NAIC MIS for use in market analysis.

4. Adopted the MIS data analysis metrics and recommendations.

5. Reviewed outstanding USER forms. NAIC staff will check on the status of the implementation of USER form 10069B to add complaint codes for lender-placed insurance in the NAIC Complaints Database System (CDS).

Producer Licensing (D) Task Force

March 26, 2021 (in lieu of the Spring National Meeting)

1. Adopted its Nov. 13, 2020, minutes.

2. Heard an update on the state implementation of online examinations. Thirty-two states have implemented online examinations, and three states are scheduled to implement online examinations by the end of April. The Task Force co-chairs polled the remaining states, and 13 additional states are moving toward implementation of remote examinations. Only three states have decided not to implement remote examinations at this time. The Producer Licensing Uniformity (D) Working Group will review the examination standards in the State Licensing Handbook to ensure that it is consistent with the state practices of implementing remote examinations.

3. Heard a briefing on the National Association of Registered Agents and Brokers Reform Act of 2015 (NARAB II), which is a federal law that sets nonresident producer license qualifications on a multi-state basis. The briefing addressed the impact on state producer licensing and included an overview of the National Association of Registered Agents and Brokers (NARAB) structure and governance, the timeline of activities since the adoption of NARAB II, and the responsibilities of the NARAB board.

4. Adopted the report of the Producer Licensing Uniformity (D) Working Group, including its March 18 minutes. During this meeting, the Working Group took the following action:
   A. Discussed licensing standards for pet insurance. The Working Group discussed three options:
      1. Confirm that the current uniform licensing standards for pet insurance are the correct policy direction.
      2. Recommend that pet insurance become a core limited line that all states shall adopt.
      3. Recommend that the property/casualty (P/C) major lines of authority be required to sell pet insurance.

5. Adopted the report of the Uniform Education (D) Working Group, including its March 2 minutes. During this meeting, the Working Group took the following action:
   A. Discussed the NAIC Continuing Education Reciprocity (CER) Agreement – 2019 Version, which 44 jurisdictions have signed.
   B. Discussed exam pass rates and a new process of obtaining and posting annual state exam pass rates from testing vendors.
   C. Discussed continuing education (CE) course instructor requirements and how to create greater uniformity among the states.

6. Received a report from the National Insurance Producer Registry (NIPR) Board of Directors. NIPR launched a major upgrade to its Attachments Warehouse application used to enable insurance producers and other licensees to upload licensing-related documents for review by state insurance regulators. NIPR processed 38 million credentialing and report transactions in 2020, a 5.2% increase from 2019. NIPR had $47.9 million in revenue in 2020, a 5.7% increase from 2019. The NIPR Board of Directors approved the 2021–2023 NIPR Strategic Plan – Our Bridge to the Future. The plan has the following three areas of focus: a) engaged and empowered team; b) customer-focused excellence; and c) high-quality and reliable technology.

7. Heard comments from the American Council of Life Insurers (ACLI) on how the NAIC’s initiatives on race and insurance relate to insurance producers and the desire to increase the number of minority insurance producers.

8. Discussed the Procedures for Amending Uniform Licensing Applications. These procedures set forth the process for making changes to the applications while maintaining stable applications that comply with state statutes and regulations.

9. Reported that the Task Force will be receiving a referral from the Special (EX) Committee on Race and Insurance and the Cannabis Insurance (C) Working Group on whether prior criminal charges are impeding individuals from obtaining an insurance producer license.

FINANCIAL CONDITION (E) COMMITTEE

April 13, 2021

1. Adopted its March 8, 2021, and 2020 Fall National Meeting minutes, which included the following action:
   A. Adopted an updated request from the Mortgage Guaranty Insurance (E) Working Group for an extension to draft amendments to the Mortgage Guaranty Insurance Model Act (#630).
B. Adopted the following new 2021 charge for the Qualified Jurisdiction (E) Working Group, including renaming the Working Group to the Mutual Recognition of Jurisdictions (E) Working Group and repositioning it to report directly to the Committee:
1. The Mutual Recognition of Jurisdictions (E) Working Group will “[d]evelop a process for evaluating jurisdictions that meets the NAIC requirements for recognizing and accepting the NAIC Group Capital Calculation (GCC).”
C. Adopted proposed recommendations to the Financial Regulation Standards and Accreditation (F) Committee with respect to the GCC and the liquidity stress test (LST).
3. Adopted the report of the Capital Adequacy (E) Task Force. See the Task Force listing for details.
4. Adopted the report of the Examination Oversight (E) Task Force. See the Task Force listing for details.
5. Adopted the report of the Financial Stability (E) Task Force. See the Task Force listing for details.
6. Adopted the report of the Receivership and Insolvency (E) Task Force. See the Task Force listing for details.
7. Adopted the report of the Reinsurance (E) Task Force. See the Task Force listing for details.
9. Adopted the report of the Valuation of Securities (E) Task Force. See the Task Force listing for details.
10. Adopted the report of the Group Capital Calculation (E) Working Group, including its March 10 minutes. During this meeting, the Working Group took the following action:
A. Adopted its Feb. 25, 2021; Jan. 28, 2021; Jan. 19, 2021; and 2020 Fall National Meeting minutes, which included the following action:
1. Adopted recommended accreditation standards for referral to the Financial Condition (E) Committee related to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). The recommendations were exposed Jan. 19 for a public comment period ending Feb. 9.
2. Adopted a recommendation to the Financial Condition (E) Committee to modify the charges of the Qualified Jurisdiction (E) Working Group and rename the Working Group to be more encompassing.
3. Heard a presentation on the data analysis for the adopted GCC template using 2019 field test data.
4. Discussed future GCC data collection.
B. Discussed conducting a 2021 GCC trial implementation and directed NAIC staff to develop and finalize a template letter that can be distributed by lead states to insurance groups they oversee and who the lead state would like to participate in the 2021 GCC trial implementation.
11. Adopted the report of the Group Solvency Issues (E) Working Group, including its March 18 minutes. During this meeting, the Working Group took the following action:
A. Heard a report on group-related activities of the International Association of Insurance Supervisors (IAIS).
B. Received the report of the Own Risk and Solvency Assessment (ORSA) Implementation (E) Subgroup, which met March 10 in regulator-to-regulator session, pursuant to paragraph 6 (consultation with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings, to discuss matters regarding the timely receipt and review of ORSA filings and to receive an update on NAIC ORSA training initiatives.
C. Received an update on the progress of the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) drafting group, which indicated:
1. The financial analysis drafting group has met five times since being formed in August 2020, and it has made significant progress in incorporating ComFrame elements into draft revisions to the Financial Analysis Handbook.
2. The drafting group anticipates completing its work over the next month and then providing the proposed revisions to the full Working Group for public exposure and further consideration.
3. After the financial analysis drafting work is completed, drafting work is expected to begin on financial examination and ORSA topics.
D. Discussed an item referred from the 2020 Financial Sector Assessment Program (FSAP), which recommended that state insurance regulators coordinate and leverage the expertise of teams of supervisors conducting financial surveillance of large insurance groups, including internationally active insurance groups (IAIGs). As a result of the discussions, the Working Group agreed to incorporate this recommendation into its ComFrame implementation efforts.
12. Adopted the report of the Mortgage Guaranty Insurance (E) Working Group, including its April 6 minutes. During this meeting, the Working Group took the following action:
A. Discussed comments received on a draft 2021 annual property/casualty (P/C) financial statement exhibit proposal regarding the collection of mortgage guaranty insurance data. The draft proposal was exposed for a 30-day public
comment period. One comment letter from the mortgage guaranty consortium was received. As a result of the discussion, several modifications to the draft will be implemented.

13. Adopted the report of the National Treatment and Coordination (E) Working Group, including its March 4 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its revised 2021 charges, which included disbanding the Biographical Third-Party Review (E) Subgroup.
   B. Discussed a referral submitted by the Chief Regulator Forum regarding change of control. The Working Group will continue discussing this referral during future meetings to determine the best solution on where instructions or enhancements should be added to current processes.
   C. Exposed proposal 2021-01 for a 45-day public comment period ending April 19.
   D. Exposed proposal 2021-02 for a 45-day public comment period ending April 19.
   E. Received a status update on the Electronic Application Ad Hoc Group. The ad hoc group began meeting in August 2020 to gather business rules for the primary (startup) application and then the redomestication application. The ad hoc group is currently discussing business rules for domestic corporate amendment applications.
   F. Received a status update on the Domestic Surplus Lines Ad Hoc Group. The ad hoc group was formed in 2020 based on a referral from the Chief Regulator Forum regarding domestic surplus lines carriers. The ad hoc group will determine which states have enacted the new legislation and identify similarities that can be incorporated into regulatory guidance.
   G. Discussed possible enhancements to Form 2 and Form 14 of the NAIC Uniform Certificate of Authority Application (UCAA).
   H. Discussed the company licensing collaboration page.


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

16. Appointed the new Receiver’s Handbook (E) Subgroup and adopted the following related charge:
   A. Review the *Receiver’s Handbook for Insurance Company Insolvencies* (Receiver’s Handbook) to identify areas where information is outdated, updates are required, or additional guidance is needed. Based on this review, draft and propose recommended edits to the Receiver’s Handbook. Complete by the 2022 Fall National Meeting.

**Accounting Practices and Procedures (E) Task Force**

March 23, 2021 *(in lieu of the Spring National Meeting)*

1. Adopted its 2020 Fall National Meeting minutes.
2. Reported that it met March 16 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings.
3. Adopted the report of the Statutory Accounting Principles (E) Working Group, including its March 15 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its Jan. 25, 2021; Jan. 6, 2021; Dec. 28, 2020; Dec. 18, 2020; Dec. 8, 2020; and Nov. 12, 2020, minutes. The interim minutes included the following adoptions to Appendix B—Interpretations of Statutory Accounting Principles (INTs):
      1. Extended INT 20-03: Troubled Debt Restructuring Due to COVID-19 and INT 20-07: Troubled Debt Restructuring for Certain Debt Instruments Due to COVID-19 through Jan. 1, 2022, or the date that is 60 days after the date on which the national emergency concerning the COVID-19 outbreak terminates.
      2. INT 20-10: Reporting Nonconforming Credit Tenant Loans: This INT allows nonconforming credit tenant loans (CTLs) to continue to be reported on Schedule D, Part 1 – Long-Term Bonds if filed with the NAIC Securities Valuation Office (SVO) by Feb. 15, 2021. The provisions within this INT and the ability to continue reporting nonconforming CTLs on Schedule D, Part 1 with an SVO-assigned NAIC designation are limited time exceptions that extend only to Oct. 1, 2021.
      3. INT 20-11: Extension of Ninety-Day Rule for the Impact of 2020 Hurricanes, California Wildfires and Iowa Windstorms: This INT provides a 60-day extension from the 90-day rule for uncollected premium balances, bills receivable, and amounts due from agents and for policies directly affected by the noted events. This INT expires Feb. 28, 2021.
   B. Adopted the following nonsubstantive revisions to statutory accounting guidance:
      1. *Statement of Statutory Accounting Principles (SSAP) No. 5R—Liabilities, Contingencies and Impairments of Assets, SSAP No. 72—Surplus and Quasi-Reorganizations, and SSAP No. 86—Derivatives: Revisions reject Accounting Standards Update (ASU) 2020-06, Debt—Debt with Conversion and Other Options*
5. SSAP No. 86: Interpretative revisions expose a temporary (optional) expedient and exception guidance for asset held in a foreign subsidiary should not be valued in a more favorable manner than had they been held.

4. SSAP No. 26R—Bonds:
   a. Revisions clarify that perpetual bonds are within the scope of SSAP No. 26R, and they are subject to the yield-to-worst concept. Additionally, perpetual bonds that possess a future call date will retain bond accounting (i.e., accounted for at amortized cost); however, if a perpetual bond does not possess a future call date, fair value accounting is required, regardless of NAIC designation. (Ref #2020-22)
   b. Revisions expand the current called bond disclosures to also include bonds terminated early through a tender offer. (Ref #2020-32)

3. SSAP No. 26R—Preferred Stock and SSAP No. 86: Revisions direct that publicly traded preferred stock warrants are in the scope of SSAP No. 32R, and they shall be reported at fair value. (Ref #2020-33)

2. SSAP No. 43R—Loan-Backed and Structured Securities: Revisions incorporate minor scope modifications to reflect recent changes to the Federal Home Loan Mortgage Corporation (Freddie Mac) Structured Agency Credit Risk (STACR) and Federal National Mortgage Association (Fannie Mae) Connecticut Avenue Securities (CAS) programs, which allow credit risk transfer securities from these programs to remain in the scope of SSAP No. 43R when issued through a real estate mortgage investment conduit (REMIC) structure. (Ref #2020-34)

1. SSAP No. 71—Policy Acquisition Costs and Commissions: Revisions clarify the guidance in SSAP No. 71 regarding levelized commissions, with a Dec. 31, 2021, effective date. The Working Group affirmed the nonsubstantive classification of these revisions as consistent with the original intent of SSAP No. 71. In addition, the Working Group exposed a new annual statement general interrogatory to identify the use of a third party for the payment of commission expenses, which will be concurrently exposed with the Blanks (E) Working Group. (Ref #2019-24)

Appendix D—Nonapplicable GAAP Pronouncements: Revisions reject ASU 2020-07, Not-for-Profit Entities (Topic 958): Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets as not applicable for statutory accounting. (Ref #2020-42)

Appendix F—Policy Statements: Revisions to the NAIC Policy Statement on Maintenance of Statutory Accounting Principles clarify the existing process regarding the Working Group’s issuance and adoption of accounting interpretations. (Ref #2020-39)

Preamble: Revisions clarify that while any state in which a company is licensed can issue prescribed practices, the prescribed practices directed by the domiciliary state: a) shall be reflected in the financial statements filed with the NAIC; and b) are the financial statements subject to independent audit requirements. (Ref #2020-40)

Exposed the following nonsubstantive revisions to statutory accounting guidance:

1. SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments: Exposed the interpretative guidance provided by INT 21-01T: Statutory Accounting Treatment for Cryptocurrencies, which clarifies that cryptocurrencies do not meet the definition of cash in SSAP No. 2R, and they are nonadmitted assets for statutory accounting. Requested comments on the level of interest and ownership of cryptocurrencies. (Ref #2021-05)

2. SSAP No. 26R: Revisions reject ASU 2020-08, Codification Improvements to Subtopic 310-20, Receivables—Nonrefundable Fees and Other Costs for statutory accounting. (Ref #2021-02)

3. SSAP No. 47—Uninsured Plans: Revisions reject ASU 2021-02, Franchisors—Revenue from Contracts with Customers (Subtopic 952-606): Practical Expedient in SSAP No. 47. (Ref #2021-08)

4. SSAP No. 86: Interpretative revisions expose a temporary (optional) expedient and exception guidance for ASU 2021-01, Reference Rate Reform (Topic 848): Scope, with an expiration date of Dec. 31, 2022. The optional expedients would expand the current exceptions provided by INT 20-01: ASU 2020-04—Reference Rate Reform. The exceptions allow for the continuation of the existing hedge relationship, and thus not requiring hedge dedesignation for derivative instruments affected by changes to interest/reference rates due to reference rate reform, regardless of whether they reference the London Interbank Offered Rate (LIBOR) or another rate that is expected to be discontinued. The exception in INT 20-01 would apply for affected derivatives used for discounting, margining or contract price alignment. (Ref #2021-01)

5. SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities: Exposed this agenda item with the intent to dispose without statutory edits. NAIC staff note that the long-standing, required statutory adjustments to SSAP No. 97, paragraph 8.b.iv. – Foreign Insurance SCA Entities could result in negative equity valuation, as assets held in a foreign subsidiary should not be valued in a more favorable manner than had they been held...
directly by the insurer. Industry comments are requested regarding detailed instances of negative value subsidiary, controlled and affiliated entities (SCAs). (Ref #2021-04)

6. **SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities**: Revisions propose data-captured templates for existing disclosures in SSAP No. 103R, which are currently only completed in narrative form. Data-capturing of such items will permit state insurance regulators to submit system inquiries to determine the extent to which reporting entities have transferred (sold), but still retain, a material participation with said assets. A blanks proposal will be concurrently exposed with the Working Group’s exposure. (Ref #2021-03)

7. **SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act**: Revisions include state Affordable Care Act (ACA) reinsurance programs, which are using Section 1332 waivers in the scope of SSAP No. 107. The revisions continue to follow the hybrid accounting approach for the state ACA programs, as they operate in a similar manner. (Ref #2021-09)

8. **SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees**: Re-exposed this agenda item to provide additional time for interested parties to develop a proposal for establishing accounting and reporting guidance for derivatives hedging the growth in interest for fixed indexed products. (Ref #2020-36)

9. **Appendix D**: Revisions reject ASU 2020-11, Financial Services—Insurance (Topic 944): Effective Date and Early Application for statutory accounting. This ASU was issued to address the effective dates of ASU 2019-09, Financial Services—Insurance (Topic 944): Effective Date and ASU 2018-12, Financial Services—Insurance (Topic 944): Targeted Improvements to the Accounting for Long-Duration Contracts, both of which were previously rejected by the Working Group. (Ref #2021-07)

10. **Blanks:**
   a. Re-exposed this agenda item for a concurrent exposure with the Blanks (E) Working Group of blanks agenda item 2021-03BWG to modify the current General Interrogatory instructions and require that a distinct disaggregated product identifier be used for each product represented. The disaggregation will require that each separate account product filing or policy form be separately identified. The instructions will also indicate that companies may eliminate proprietary information; however, the elimination will still require the use of a unique reporting identifier. (Ref #2020-37)
   b. Re-exposed this agenda item for a concurrent exposure with the Blanks (E) Working Group. The Working Group is sponsoring blanks agenda item 2021-03BWG to clarify reporting by each separate product filing or policy form and add product identifiers, specifically for Pension Risk Transfer (PRT) and Registered Index-Linked Annuity (RILA) transactions in the Separate Account General Interrogatories. (Ref #2020-38)

D. Exposed the following editorial revisions (Ref #2021-06EP):
   1. **SSAP No. 53—Property Casualty Contracts – Premiums**: Revisions retitle to SSAP No. 53—Property and Casualty Contracts – Premiums.
   2. **SSAP No. 97**: Revisions correct grammatical errors in paragraph 54.
   3. **SSAP Glossary**: Revisions remove the footnote in the Glossary title and replace it as an opening paragraph with updated verbiage.

E. Disposed the following without revisions to statutory accounting guidance:
   1. Agenda item 2020-35: SSAP No. 97 – Audit Opinions was disposed without statutory revisions, as the issue of nonadmittance due to the inability to quantify a departure from U.S. generally accepted accounting principles (GAAP) was not deemed prevalent. (Ref #2020-35)

F. Received an update on the following projects and referrals:
   1. Received an update that NAIC staff, industry, and key state insurance regulators have made significant progress on agenda item 2019-21: SSAP No. 43R – Investment Classification Project. While discussions remain ongoing, it is anticipated that a public exposure will occur via an interim call prior to the Summer National Meeting. The exposure will include additional concepts on which investments are eligible for reporting on Schedule D as a bond.
   2. Received an update that INT 19-02: Freddie Mac Single Security Initiative remains in full effect. The Freddie Mac Single Security Initiative remains an ongoing program, and it does not appear to be subject to termination in the foreseeable future.
   3. Received an update on agenda item 2019-49: Retroactive Reinsurance Exception. This agenda item addresses a referral from the Committee on Property and Liability Financial Reporting (COPLFR) of the American Academy of Actuaries (Academy), which noted diversity in reporting regarding companies applying the retroactive reinsurance exception, which allows certain contracts to be reported prospectively. NAIC staff have held preliminary discussions with Casualty Actuarial and Statistical (C) Task Force members, with a preliminary
recommendation that the premium and losses transferred under such transactions should be allocated to the prior Schedule P calendar year premiums and the losses allocated to the prior accident year incurred losses.

4. Received an update on the reporting and extinguishment of loans received from the federal Paycheck Protection Program (PPP). For statutory accounting, the authoritative guidance in SSAP No. 15—Debt and Holding Company Obligations paragraph 11 provides that debt is recognized until extinguished, including formally being forgiven. In addition, per SSAP No. 15 paragraph 25, gains on termination of debt are recognized as capital gains.

5. Received an update on the Valuation of Securities (E) Task Force discussion regarding revisions to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) as coordination regarding the revisions to SSAP No. 105R—Working Capital Finance Investments adopted by the Working Group in May 2020 (agenda item 2019-25). At its Nov. 18, 2020, meeting, the Task Force directed a referral to the Working Group, which is still pending. NAIC staff anticipate addressing this referral when received.

6. Received an update on current U.S. GAAP exposures/invitations to comment, noting that no comments by the Working Group are planned during the exposure periods.

G. The public comment period for all exposed agenda items ends April 30.

Capital Adequacy (E) Task Force
March 23, 2021 (in lieu of the Spring National Meeting)

1. Adopted its Feb. 1, 2021, and 2020 Fall National Meeting minutes, which included the following action:
   A. Adopted updates to proposal 2020-12-CR (2020 Catastrophe Event Lists).

2. Adopted the report of the Health Risk-Based Capital (E) Working Group, including its March 17 minutes. During this meeting, the Working Group took the following action:
   A. Reported that it met March 5 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss the company-specific impact analysis.
   B. Adopted its Feb. 10 minutes, which included the following action:
      1. Discussed the impact analysis on investment income in underwriting risk.
      2. Exposed proposal 2021-02-CA (Managed Care Credit – Incentives) for a 30-day public comment period ending March 12.
      3. Discussed the bond factor impact analysis.
   C. Adopted its Jan. 22 minutes, which included the following action:
      1. Discussed the American Academy of Actuaries (Academy) report on investment income in underwriting risk.
   D. Adopted its Dec. 18, 2020, minutes, which included the following action:
      1. Referred a blanks proposal regarding health care receivables to the Blanks (E) Working Group for consideration in 2021 reporting.
      2. Exposed the Academy report on investment income in underwriting risk for a 30-day public comment period ending Jan. 18.
      3. Received a summary of the Blanks (E) Working Group’s proposals related to health business reporting.
      4. Discussed the next steps for the Health Test Ad Hoc Group.
   E. Adopted its 2021 working agenda.
   F. Referred proposal 2021-02-CA (Managed Care Credit – Incentives) to the Capital Adequacy (E) Task Force.
   G. Heard an update from the recommended underwriting factors adjusted for investment income. The Working Group discussed the impact analysis for including the adjusted factors for a 0.5%, 1%, 1.5% and 2% return yield and the frequency for adjusting the factors.
   H. Exposed proposal 2021-04-CA (Investment Income Adjustment to Underwriting Risk Factors) for a 30-day public comment period ending April 16.
   I. Received an update on the bond factor impact analysis.

3. Adopted the report of the Life Risk-Based Capital (E) Working Group, including its March 12 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its Feb. 26, 2021; Feb. 11, 2021; Jan. 21, 2021; Dec. 17, 2020; and Nov. 10, 2020, minutes, which included the following action:
      1. Adopted an update to the mortgage reporting guidance. Proposed guidance was exposed Feb. 11 for a 10-day public comment period ending Feb. 22.
      2. Discussed and exposed the real estate proposal submitted by the American Council of Life Insurers (ACLI).
      3. Discussed the Moody’s Analytics report on bonds.
      4. Adopted revisions to its working agenda.
5. Agreed to forward a guaranty fund memorandum to the Capital Adequacy (E) Task Force.
6. Received an update on work being done by the Life Actuarial (A) Task Force on economic scenario generators (ESGs).

B. Continued discussion of the ACLI’s real estate proposal.

4. Adopted the report of the Property and Casualty Risk-Based Capital (E) Working Group, including its March 15 minutes. During this meeting, the Working Group took the following action:
   A. Adopted the Catastrophe Risk (E) Subgroup’s March 8 minutes, which included the following action:
      1. Adopted its Jan. 27 minutes, which included the following action:
      2. Adopted proposal 2020-08-CR (Clarification to PR027 Interrogatories).
      3. Adopted proposal 2020-11-CR (Remove Operational Risk Factor from Rcat).
      4. Discussed the progress of developing wildfire modeling and a risk-based capital (RBC) charge.
      5. Discussed its 2021 working agenda.
      6. Discussed the internal catastrophe model evaluation process.
      7. Created an ad hoc group to conduct a more in-depth review on different wildfire models.
   B. Adopted its Jan. 27 minutes, which included the following action:
   C. Adopted proposal 2020-08-CR (Clarification to PR027 Interrogatories).
   D. Adopted proposal 2020-11-CR (Remove Operational Risk Factor from Rcat).
   E. Received an update from the Catastrophe Risk (E) Subgroup on the development process of wildfire modeling and an RBC charge.
   F. Exposed proposal 2021-03-P (Credit Risk Instruction Modification) for a 30-day public comment period ending April 14.
   G. Received an update from its Runoff Ad Hoc Group, which was created to determine the best course of treatment of companies in runoff. The ad hoc group is reviewing: 1) the possibility of adding an identifier in the annual financial statement; and 2) the current RBC calculation, including R5 and the operational risk component.
   H. Adopted its 2021 working agenda.
   I. Heard an update from the Academy on the development of the property/casualty (P/C) RBC underwriting risk factors.
5. Received a guaranty fund memorandum from the Life Risk-Based Capital (E) Working Group.
7. Exposed proposal 2021-02-CA (Managed Care Credit – Incentives) for a 30-day public comment period ending April 22.
8. Adopted proposal 2020-08-CR (Clarification to PR027 Interrogatories).
10. Adopted its 2021 working agenda.

Examination Oversight (E) Task Force
March 25, 2021 (in lieu of the Spring National Meeting)

1. Adopted its Nov. 17, 2020, minutes.
2. Adopted the report of the Electronic Workpaper (E) Working Group, which met March 15 and Jan. 27 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings.
3. Adopted the report of the Financial Examiners Coordination (E) Working Group, which met March 18 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.
4. Adjourned into regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to receive reports on exams open past 22 months.

Financial Stability (E) Task Force
Feb. 22, 2021 (in lieu of the Spring National Meeting)

2. Announced the membership of the Liquidity Assessment (E) Subgroup and its 2021 charges.
3. Received the report of the Receivership and Insolvency (E) Task Force regarding its disposition of referrals from the Financial Stability (E) Task Force.
4. Adopted recommendations to the Financial Condition (E) Committee regarding the liquidity stress test (LST) revisions to the Insurance Holding Company System Regulatory Act (#440). The Task Force believes the revisions should be required for accreditation purposes.

Receivership and Insolvency (E) Task Force
March 12, 2021 (in lieu of the Spring National Meeting)

1. Adopted its Nov. 19, 2020, minutes.
2. Adopted the report of the Receivership Financial Analysis (E) Working Group, which met Feb. 1 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss experiences and the need for best practices for data transfer from insurance companies in liquidation to guaranty funds. The Working Group met March 22, in lieu of the Spring National Meeting, in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.
3. Adopted the report of the Receivership Law (E) Working Group, including its March 4 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its Feb. 4 minutes, which included the following action:
      1. Adopted its Dec. 17, 2020, minutes, which included the following action:
         a. Exposed proposed amendments to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) for a 35-day public comment period ending Jan. 29.
         2. Discussed comments received on proposed revisions to Model #440 and Model #450.
         3. Exposed proposed revisions to Model #440 and Model #450 for a 14-day public comment period ending Feb. 26.
   B. Reported that it met Feb. 18 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings.
   C. Discussed comments received on proposed revisions to Model #440 and Model #450.
   D. Exposed proposed revisions to Model #440 for a 30-day public comment period ending April 9.
4. Adopted the Guideline for Definition of Reciprocal State in Receivership Laws. This guideline provides an optional definition of “reciprocal state” for receivership laws that is intended to effectuate the recognition of stays and injunctions in a receivership affecting multiple states.
5. Appointed the Receiver’s Handbook (E) Subgroup to review and draft updates to the Receiver’s Handbook for Insurance Company Insolvencies and adopted the Subgroup’s 2021 proposed charges.
6. Heard an update on the status of Macropudential Initiative (MPI) recommendations:
   A. The Task Force will not recommend any changes to the current Part A: Accreditation Standards for Receivership and Guaranty Fund Laws or related interlineations.
   B. The Task Force will pursue training and outreach to better inform states of receivership matters. Possible activities include outreach to states’ legislative liaisons, providing legal training webinars, and encouraging that Task Force members highlight receivership matters at zone meetings.
   C. The Task Force will continue to monitor and provide feedback to the Group Solvency Issues (E) Working Group once it completes drafting updates to financial analysis guidance for crisis management groups, recovery planning, and resolution planning.

Reinsurance (E) Task Force
March 23, 2021 (in lieu of the Spring National Meeting)

1. Adopted its 2020 Fall National Meeting minutes.
2. Adopted the report of the Reinsurance Financial Analysis (E) Working Group, which met Jan. 28 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss the application of one new certified reinsurer.
3. Adopted the report of the Qualified Jurisdiction (E) Working Group, which met March 17 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) and paragraph 8 (considerations of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to:
   A. Discuss the initial review of a country being evaluated as a qualified jurisdiction.
   B. Provide updates on a previous initial review.
   C. Conduct ongoing business.
4. Reported that the Financial Condition (E) Committee met March 8 and adopted a recommendation from the Group Capital Calculation (E) Working Group to:
   A. Reposition the Qualified Jurisdiction (E) Working Group to report directly to the Committee.
   B. Modify the Working Group’s 2021 charges to include developing a process for evaluating jurisdictions that meet the NAIC requirements for recognizing and accepting the group capital calculation (GCC).
   C. Rename the group to be the Mutual Recognition of Jurisdictions (E) Working Group.
5. Exposed proposed revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions for a 30-day public comment period ending April 23.
6. Received a status report on the states’ implementation of the 2019 revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786). As of March 18, 23 jurisdictions have enacted the revisions to Model #785, while 21 jurisdictions have action under consideration; and eight jurisdictions have adopted the revisions to Model #786, while six jurisdictions have action under consideration.

Risk Retention Group (E) Task Force
Feb. 24, 2021 (in lieu of the Spring National Meeting)
1. Adopted its Feb. 5, 2021, and 2020 Fall National Meeting minutes, which included the following action:
   A. Approved the distribution of a survey to state insurance regulators, with the purpose to provide the Task Force with insight into future improvements and priorities in the areas of risk retention group (RRG) regulation, registration and training.
2. Discussed the applicability of the 2020 revisions to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) related to the GCC as an accreditation standard for RRGs.
3. Discussed the need for revisions relating to RRGs to the Financial Analysis Handbook, Section III.A.3 Risk Assessment (All Statement Types) – Quarterly Quantitative Assessment of Non-Troubled Insurers. NAIC staff will draft a referral to the Financial Analysis Solvency Tools (E) Working Group for the Task Force to consider during its next meeting.
4. Discussed the survey sent to state insurance regulators in February, noting that it had a due date of March 1.
5. Discussed training initiatives, noting that a training session would be conducted at the virtual NAIC Insurance Summit.

Valuation of Securities (E) Task Force
March 22, 2021 (in lieu of the Spring National Meeting)
1. Adopted its Feb. 18, 2021; Dec. 18, 2020; and 2020 Fall National Meeting minutes, which included the following action:
   A. Exposed a proposed amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to update the financial modeling instructions for residential mortgage-backed securities (RMBS)/commercial mortgage-backed securities (CMBS) for non-legacy securities for a 30-day public comment period ending March 20.
   B. Discussed comments received on a proposed amendment to the P&P Manual to require the filing of private rating letter rationale reports. The Task Force directed NAIC staff to continue working with interested parties.
   C. Received a referral from the Statutory Accounting Principles (E) Working Group on non-conforming credit tenant loans (CTLs); specifically, about the residual risk threshold. NAIC staff are going to draft a memorandum that will address whether, in their opinion, it is appropriate to revisit the 5% residual risk threshold.
   D. Exposed a proposed amendment to the P&P Manual to update the NAIC List of Credit Rating Providers to reflect changes to nationally recognized statistical rating organizations (NRSROs) for a 30-day public comment period ending March 20.
   E. Discussed the U.S. Securities and Exchange Commission (SEC) Rule 18f-4 under the federal Investment Company Act of 1940 related to the use of derivatives by registered investment companies. The Task Force directed NAIC staff to prepare a P&P Manual amendment on the use of derivatives by funds for the Task Force to consider.
   F. Exposed an updated amendment to the P&P Manual to include instructions for financially modeled RMBS/CMBS to map NAIC designation categories for a three-day public comment period ending Dec. 22, 2020.
   G. Discussed financially modeled RMBS/CMBS price breakpoints and other issues surrounding securities that have a zero loss in 2020.
2. Adopted an amendment to the P&P Manual to update the financial modeling instructions for RMBS/CMBS.
3. Discussed additional updates on a P&P Manual amendment to require the filing of a private rating letter rationale report. The Task Force directed NAIC staff to continue working with interested parties and expose the final version for a 30-day public comment period.
4. Adopted an amendment to the P&P Manual to update the NAIC List of NAIC Credit Rating Providers to reflect changes to NSROs.

5. Received a request from the American Council of Life Insurers (ACLI) to study the national financial presentation standard for Spanish generally accepted accounting principles (GAAP). The Task Force directed NAIC staff to begin the study and report back to the Task Force with their findings; recommendations; and if appropriate, a possible amendment to the P&P Manual.

6. Exposed a proposed amendment to the P&P Manual to clarify guidance for fund leverage for a 45-day public comment period ending May 6.

7. Heard NAIC staff reports on:
   B. A referral from the Statutory Accounting Principles (E) Working Group regarding CTLs.
   C. The status of the NAIC Securities Valuation Office (SVO) on year-end carry-over filings for 2020.

FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

April 12, 2021

1. Adopted its 2020 Fall National Meeting minutes.

2. Adopted, immediately by reference, revisions made during 2020 to NAIC publications that are required for accreditation purposes (e.g., the Accounting Practices and Procedures Manual [AP&P Manual]) and were deemed insignificant.

3. Exposed the proposed revisions to the Part A: Laws and Regulations Preamble for a 30-day public comment period ending May 13. The proposed revisions update the XXX/AXXX Captive Reinsurance Framework references to the Term and Universal Life Insurance Reserve Financing Model Regulation (#787), which is effective for accreditation Sept. 1, 2022.

4. Exposed the 2020 revisions to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) for a 30-day public comment period ending May 13, with the recommendation that the revisions will be effective for all states Jan. 1, 2026. The revisions implement the group capital calculation (GCC) for the purpose of group solvency supervision and the liquidity stress test (LST) for macroprudential surveillance.

5. Reported that it met April 8 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, to:
   A. Discuss state-specific accreditation issues.
   B. Vote to award continued accreditation to the insurance departments of New Mexico and Tennessee.

INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

April 7, 2021

1. Adopted its March 25, 2021; Feb. 3, 2021; Jan. 6, 2021; and 2020 Fall National Meeting minutes, which included the following action:
   A. Approved submission of NAIC comments on the International Association of Insurance Supervisors (IAIS) draft Application Paper on Supervision of Control Functions.
   B. Approved submission of NAIC comments on the IAIS draft Application Paper on Resolution Powers and Planning and the consultation on the development of liquidity metrics.
   C. Approved submission of NAIC comments on the joint Sustainable Insurance Forum (SIF) and IAIS draft Application Paper on the Supervision of Climate-Related Risks in the Insurance Sector.

2. Heard an update on key 2021 projects and priorities of the IAIS, including:
   A. Implementation assessment activities related to the holistic framework for systemic risk.
   B. The ongoing insurance capital standard (ICS) monitoring period and expected timeline.
   C. Activities and priorities related to climate risk and sustainability.
   D. The ongoing global impact of COVID-19 on supervisors and the insurance sector.

3. Heard a presentation on scalar methodologies from the American Academy of Actuaries (Academy).

4. Heard an update on international activities, including recent virtual meetings and events with international colleagues; plans for a virtual spring 2021 NAIC International Fellows Program; recent meetings of the Organisation for the Economic Co-Operation Development (OECD) Insurance and Private Pensions Committee and Environment Directorate; recent meetings of the SIF and other regional supervisory dialogues; and the upcoming virtual 2021 NAIC International Insurance Forum.
COGRAPHICAL COMMITTEE
April 8, 2021
1. Heard a presentation on federal health care reform developments and recommendations for the states. This presentation is important to consumers and state insurance regulators because it recommended actions for the states to implement using additional funding provided by the federal American Rescue Plan Act of 2021 (ARPA) to enable uninsured persons to obtain health plans with no cost-sharing, especially those in underserved communities, such as immigrants and their family members.
2. Heard a presentation on the enforcement needed to ensure health plan compliance with HIV preventative drug requirements. This presentation is important to consumers because it highlighted the inadequacy of plans to make the regimen of pre-exposure prophylaxis (PrEP) affordable and/or available for zero cost, especially to Black and Hispanic/Latino communities that are disproportionately affected by HIV, as a preventative that reduces the risk of contracting HIV by approximately 99%.
3. Heard a presentation on how state insurance regulators can help improve maternal health outcomes for Black, Native American and Latina women experiencing disparities in maternal and infant health care, coverage and community due to bias and a lack of education and understanding of cultural differences. This presentation is important to consumers because it helps the states to identify areas of inadequacy in maternal care that need attention.
4. Heard a presentation on addressing coverage losses among kids, which is important to the states and consumers because it emphasized that the number of uninsured children has risen drastically, affecting millions of low-income, Black, Hispanic/Latino and immigrant children. New policies implemented in Colorado and Utah have promoted much-needed coverage and care for many of these children and provided templates that other states could utilize for uninsured children in their own communities.
5. Heard a presentation on a comprehensive approach to addressing systemic racism in insurance. This presentation is important to consumers, the industry and the states because it educates them about how racial bias can be inadvertently included in the algorithms used for rating insurance products. It explained the differences between disparate impact and proxy discrimination in insurance.
6. Heard a presentation on the short-term and long-term recovery of Texas in the aftermath of catastrophic disaster. This presentation is important to consumers, industry, and states because it explored collaboration opportunities for optimizing disaster recovery assistance by facilitating the flow of accurate information and insurance dollars to overwhelmed, traumatized people. It described actions taken, such as the wildfire rebuild agreement, in California, Colorado and Oregon that benefited consumers.

NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE
March 16, 2021 (in lieu of the Spring National Meeting)
1. Adopted its 2020 Fall National Meeting minutes.
2. Heard a presentation on COVID-19 vaccine distribution and usage in Washington state. The presentation included best practices and lessons learned from building trusted relationships that can be used by other states in future outreach efforts.
3. Heard a presentation on suggestions for using the latest federal stimulus package. The presentation included identifying bronze and other metal level plans available for year-round enrollment with essential health benefits (EHBs) and no cost/premium to tribal members.
EXECUTIVE (EX) COMMITTEE AND PLENARY

Executive (EX) Committee and Plenary April 14, 2021, Minutes.................................................................3-2
Adopted Amendments to the Unfair Trade Practices Act (#880) (Attachment One).................................3-10
Adopted the Real Property Lender-Placed Insurance Model Act (#631) (Attachment Two)..................3-23
Adopted the Regulatory Review of Predictive Models White Paper (Attachment Three).........................3-34
Adopted the Antifraud Plan Guideline (#1690) (Attachment Four).............................................................3-90
Adopted the Guideline for Administration of Large Deductible Policies in Receivership (#1980) (Attachment Five)..................................................................................................................3-101
State Implementation Reporting of NAIC-Adopted Model Laws and Regulations (Attachment Six)........3-105
Executive (EX) Committee and Plenary
Virtual 2021 Spring National Meeting
April 14, 2021

The Executive (EX) Committee and Plenary met April 14, 2021. The following members participated: David Altmaier, Chair (FL); Dean L. Cameron, Vice Chair (ID); Chlora Lindley-Myers, Vice President (MO); Andrew N. Mais, Secretary-Treasurer (CT); Raymond G. Farmer, Most Recent Past President (SC); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Alan McClain (AR); Evan G. Daniels (AZ); Ricardo Lara represented by Bryant Henley (CA); Michael Conway (CO); Karima M. Woods represented by Sharon Shipp (DC); Trinidad Navarro (DE); John F. King represented by Martin Sullivan (GA); Colin M. Hayashida (HI); Doug Ommen (IA); Dana Popish Severyinghaus (IL); Stephen W. Robertson represented by Holly Lambert (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon (LA); Gary D. Anderson (MA); Eric A. Cioppa represented by Timothy Schott (ME); Kathleen A. Birrane (MD); Anita G. Fox (MI); Grace Arnold (MN); Mike Chaney represented by Mark Haire (MS); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Michelle Osborne (NC); Jon Godfread (ND); Bruce R. Range represented by Martin Swanson (NE); Chris Nicolopoulos (NH); Marlene Caride (NJ); Russell Toal represented by Jennifer Catechis (NM); Barbara D. Richardson (NV); Linda A. Lacewell represented by My Chi To (NY); Judith L. French (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleheer Dwyer (RI); Larry D. Deiter (SD); Carter Lawrence (TN); Doug Slape (TX); Jonathan T. Pike (UT); Scott A. White (VA); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler (WA); Mark Afable (WI); James A. Dodrill (WV); and Jeff Rude (WY).

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

Commissioner Altmaier reported that the Executive (EX) Committee met April 14 and adopted the April 7 report from the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.

The Executive (EX) Committee also adopted its interim meeting report from March 16 and Feb. 24, which included the following action: 1) adopted the March 3 minutes of the Internal Administration (EX1) Subcommittee, including investment reports and recommendations on the NAIC’s long-term investment portfolio; 2) approved next steps for the Long-Term Care Insurance (LTCI) Legal Restructuring fiscal; 3) approved the exposure of the NAIC System for Electronic Rate and Form Filing (SERFF) Modernization – Mobilization and Pilot Phase fiscal for public comment; 4) approved the State Based Systems (SBS) State Implementations 2021 fiscal for public comment; 5) approved the exposure of the Property/Casualty (P/C) Rate Model Review Staffing Resources fiscal for public comment; 6) appointed Commissioner Clark to serve on the National Insurance Producer Registry (NIPR) Board of Directors, effective April 9, 2021; 7) received an update on the 2020 year-end financial results; 8) reviewed the NAIC Conflict of Interest Policy; 9) approved moving the Financial Stability (EX) Task Force from the Executive (EX) Committee to the Financial Condition (E) Committee; 10) approved the following non-regulator appointments to the SERFF Advisory Board: Birny Birnbaum (Center for Economic Justice—CEJ) as the consumer representative; Andrea Davey (Athene Annuity and Life Company) as the life insurance representative and vice chair; Phyllis Hollerbach (Zurich North America) as the health insurance representative; and Susan Gould (The Hanover Insurance Group) as the P/C representative; 11) appointed the following members to the 2021 NAIC Consumer Participation Board of Trustees: Commissioner Conway as chair; Director Lindley-Myers; Superintendent Toal; Commissioner King; Commissioner Caride; and Commissioner Altman; 12) reappointed the following consumer representatives to serve on the 2021 Consumer Participation Board of Trustees: Amy Bach (United Policyholders); Brendan Bridgeland (Center for Insurance Research—CIR); Bonnie Burns (California Health Advocates—CHA); Brenda J. Cude (University of Georgia); Katie Keith (Out2Enroll); and Sarah Lueck (Center on Budget and Policy Priorities—CBPP); 13) approved an amendment to the NAIC Grant and Zone Fund Policy; 14) heard an update on NAIC cybersecurity; and 15) selected Las Vegas, NV, as the site of the 2025 Fall National Meeting.

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

The Executive (EX) Committee adopted a Request for NAIC Model Law Development of amendments to the Nonadmitted Insurance Model Act (#870).

The Executive (EX) Committee received the 2020 annual report of the NAIC Designation Program Advisory Board and received a status report on the NAIC State Ahead strategic plan implementation.
The Executive (EX) Committee received a status report on model law development efforts for amendments to: the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171); the Annuity Disclosure Model Regulation (#245); the Life Insurance Disclosure Model Regulation (#580); the Unfair Trade Practices Act (#880); the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450); and new models, including the Real Property Lender-Placed Insurance Model Act; the Pet Insurance Model Act; and the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act.

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

Director Cameron made a motion, seconded by Commissioner Mais, to adopt the April 14 report of the Executive (EX) Committee. The motion passed.

2. Adopted by Consent the Committee, Subcommittee and Task Force Minutes of the 2020 Fall National Meeting

Commissioner Ommen made a motion, seconded by Commissioner Conway, to adopt by consent the committee, subcommittee and task force minutes of the 2020 Fall National Meeting. The motion passed.

3. Adopted Amendments to the Unfair Trade Practices Act (#880)

Commissioner Godfread reported that the amendments to Model #880 were adopted by the Executive (EX) Committee during the 2020 Fall National Meeting.

Commissioner Godfread shared that the rebating issue began when agents/brokers discounted or shared a portion of their commission with an insured or prospective insured in order to induce them into purchasing a policy. Anti-rebating laws have been the law in some states for a long time, in some cases more than 100 years. The original goal was to ensure company solvency while also leveling the playing field for insurers and preventing unfair trade practices and discrimination.

Many states have adopted the anti-rebating language contained in Model #880, while others have crafted their own anti-rebating language. The overarching intent was to prevent insurers and producers from providing an insured or a prospective insured anything of value not specified or contained in the policy that may act as an inducement to purchase insurance.

Over the years, many states have issued various bulletins that not only provide guidance with respect to their anti-rebating law, but also carve out certain exceptions to the laws, most of which focus on the ability of insurers and agents to engage in certain promotional and advertising type activities without running afoul of the law. Over time, some stakeholders have suggested anti-rebating laws are obstacles or impediments to innovation in the insurance space, and one of the concerns specifically identified by startups and incumbents alike are the inconsistencies in anti-rebating law interpretation and practices across the states.

The Innovation and Technology (EX) Task Force began discussing rebating issues at the 2018 Summer National Meeting because of the increased interest in offering value-added products and services such as risk mitigation devices and related services that are not necessarily addressed within the applicable insurance policy language.

After finding that state interpretation and application of anti-rebating laws varies and after reviewing the history of Model #880 along with the history and the intent of the anti-rebating portion, it became clear that applying the anti-rebating laws to new insurance products and services could be challenging.

During the 2019 Summer National Meeting, the Task Force voted to move forward with the development of a Request for NAIC Model Law Development to open Model #880 to amend or add to the language in Section 4(H)(2). The request was adopted by the Task Force in October 2019 and the Executive (EX) Committee during the 2019 Fall National Meeting.

The Task Force established a model drafting group led by Superintendent Dwyer that included seven additional states (Alabama, Alaska, Iowa, Missouri, North Dakota, Ohio and Washington); consumer representatives; the industry (one startup and five other industry representatives); and one state legislator, Indiana Rep. Matt Lehman, who is president of the National Council of Insurance Legislators (NCOIL).
Several drafts were exposed for public comment and all comments were reviewed. The final draft was adopted by the Task Force on Dec. 4, 2020 and adopted by the Executive (EX) Committee on Dec. 9, 2020.

Executive Deputy Superintendent of Insurance To reported that New York submitted comments to the proposed amendments at the Task Force level addressing its concerns. She said, “Our main issue with the amendment is that it includes language that is unclear or ambiguous, leaving room for consumer discrimination, which is what we are trying to avoid.” She also said the definitions of the types of value-added products or services are not clear enough, leaving too much ambiguity about what can be provided. She said the amendments focus on the offer of products while not addressing that such products or services must also be given in a nondiscriminatory manner. She also said the amendments do not address the situation where a policy is part of a group policy. She said New York encourages those states that adopt these amendments to address the ambiguities in their legislation.

Commissioner Richardson expressed support for some of New York’s issues and for the “unlevel playing field”, noting that Section 4H(2)(f) sets up a problem not only for consumers but also for independent brokers.

Commissioner Ommen expressed general concerns about uniform application of the law, particularly where there is no central place to locate how the provisions are being interpreted in other states.

Commissioner Donelon inquired as to whether the insurance agent trade associations had weighed in on the model. Superintendent Dwyer stated that the Big I submitted written and verbal comments and PIAA was on the drafting group.

Commissioner Godfread made a motion, seconded by Commissioner Mais, to adopt the amendments to the Unfair Trade Practices Act (#880) (Attachment One). Kentucky, Louisiana, Mississippi, Nevada, New York and Washington voted against the motion. The motion passed, with California abstaining.

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

Commissioner Caride reported that the Life Insurance and Annuities (A) Committee met April 12. During this meeting, the Committee adopted its 2020 Fall National Meeting minutes and its task force and working group reports: Accelerated Underwriting (A) Working Group; Annuity Disclosure (A) Working Group; Annuity Suitability (A) Working Group; Life Insurance Illustration Issues (A) Working Group; Life Insurance Online Guide (A) Working Group; Life Actuarial (A) Task Force; Experience Reporting (A) Subgroup; Guaranteed Issue (GI) Life Valuation (A) Subgroup; Indexed Universal Life (IUL) Illustration (A) Subgroup; Longevity Risk (E/A) Subgroup; Variable Annuities Capital and Reserve (E/A) Subgroup; Valuation Manual (VM)-22 (A) Subgroup; and Retirement Security (A) Working Group.

The Committee heard an update on the Special (EX) Committee on Race and Insurance Workstream Four. Workstream Four has begun to delve into the practices and barriers that potentially disadvantage minority and underserved populations in the life insurance and annuity lines of business.

The Committee adopted modifications to its 2021 charges: 1) disbanding the Annuity Disclosure (A) Working Group pending adoption of the participating income annuity revisions to the Annuity Disclosure Model Regulation (#245); and 2) disbanding the Retirement Security (A) Working Group, as it has fulfilled its charge.

The Committee discussed life insurer practices related to COVID-19: 1) heard from the Consumer Federation of America (CFA) regarding a letter to NAIC President Altmair and the chair of the Life Insurance and Annuities (A) Committee requesting that the NAIC develop a model for life insurance underwriters who may delay or deny coverage for people who have or had COVID-19; 2) heard from the Compact regarding life insurance application questions related to COVID-19 and COVID-19 vaccinations; and 3) discussed social media misinformation that COVID-19 vaccinations will affect policyholders’ life insurance benefits.

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

Commissioner Godfread reported that the Health Insurance and Managed Care (B) Committee met April 12 and heard from Jeff Wu, Deputy Administrator, Centers for Medicare & Medicaid Services (CMS) on the Biden administration’s activities of interest to the Committee. He discussed the progress of enrollment to date in the health insurance marketplaces as part of the current special enrollment period. He also discussed the challenges to enrollment in the marketplaces, including the premium cost. Mr. Wu outlined how provisions in the recently enacted federal American Rescue Plan Act (ARPA) could address the premium cost issue for some marketplace enrollees. He also briefly touched on the recently enacted federal No Surprises Act.
and acknowledged the work of state insurance regulators in this area to address surprise bills. Mr. Wu also discussed the recent federal legislation focused on the COVID-19 pandemic.

The Committee also adopted its 2020 Fall National Meeting minutes.

The Committee received an update on the Special (EX) Committee on Race and Insurance Workstream Five related to its charge to examine and determine which practices or barriers exist in the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups in the health insurance line of business and make recommendations on action steps.

The Committee adopted the report of the Regulatory Framework (B) Task Force, but deferred adoption of the proposed new [State] Pharmacy Benefit Manager Licensure and Regulation Model Act pending further discussion.

The Committee adopted its task force, working group and subgroup reports: the Health Actuarial (B) Task Force, Senior Issues (B) Task Force; Health Innovations (B) Working Group; Consumer Information (B) Subgroup, Health Care Reform Actuarial (B) Working Group; State Rate Review (B) Subgroup; Long-Term Care Actuarial (B) Working Group; Long-Term Care Pricing (B) Subgroup; Long-Term Care Valuation (B) Subgroup; Health Innovations (B) Working Group; Regulatory Framework (B) Task Force; Accident and Sickness Insurance Minimum Standards (B) Subgroup; Employee Retirement Income Security Act (ERISA) (B) Working Group; Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group; Pharmacy Benefit Manager Regulatory Issues (B) Subgroup; Senior Issues (B) Task Force; and Long-Term Care Insurance Model Update (B) Subgroup.

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

Commissioner Schmidt reported the Property and Casualty Insurance (C) Committee met April 13. During this meeting, the Committee adopted its 2020 Summer National Meeting and 2020 Fall National Meeting minutes.

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

The Committee adopted an extension for revisions to the proposed Pet Insurance Model Act.

The Committee heard an update on recent workshops related to disaster preparedness and response, including a roundtable held with the Federal Emergency Management Agency (FEMA). The Committee appointed an NAIC/FEMA Advisory Group with the following charge: The NAIC/FEMA Advisory Group will assist state insurance regulators in engaging and collaborating with FEMA on an ongoing basis by establishing a process for the oversight, prioritization and reporting of disaster-related regional workshops and other exercises to improve disaster preparation and resilience.

The Committee also: 1) heard a presentation related to insurance rating for dog breeds, including a request for state insurance regulators to collect additional rating data and not allow the use of dangerous dog breed lists; 2) discussed the status of proposed charges related to P/C insurance issues being developed by the Special (EX) Committee on Race and Insurance; and 3) heard a report from New York state insurance regulators on its recently adopted Cyber Insurance Risk Framework, which details best practices for insurers in managing cyber insurance risk.

7. Adopted the Real Property Lender-Placed Insurance Model Act (#631)

Commissioner Schmidt reported that real property lender-placed insurance issues were explored during a 2012 NAIC public hearing, as well as addressed by a New York regulation and Florida orders.

The former Creditor-Placed Insurance Model Act Review (C) Working Group first considered revising the Creditor-Placed Insurance Model Act (#375) related to lender-placed insurance on personal and real property throughout 2015, 2016 and 2017. In July 2017, the Working Group decided to split personal property from real property and draft two different models. The Property and Casualty Insurance (C) Committee adopted this Request for NAIC Model Law Development in 2017. Since that time, the Lender-Placed Insurance Model Act (C) Working Group has been tasked with creating a new model law focusing on lender-placed homeowners’ insurance.
The Working Group reviewed sections of a draft model on various conference calls and asked for comments on an ongoing basis throughout 2017 and 2018. A draft model was exposed in March 2018 and was discussed on Sept. 18, 2018. The final draft of the model was exposed for public comment from Oct. 19, 2020, through Nov. 3, 2020.

Numerous written comments were submitted to and addressed by the Working Group, including from the CEJ, the National Consumer Law Center, a joint industry group (the American Bankers Association, the Consumer Credit Industry Association, the Council of Insurance Agents & Brokers, the National Association of Mutual Insurance Companies, and the American Property Casualty Insurance Association), as well as numerous states.

Commissioner Schmidt noted a recent comment letter from consumer groups advocating for a requirement of dual interest coverage. Commissioner Schmidt stated that both the Working Group and the Committee had discussed the issue and had determined not to include such a requirement. Commissioner Mais suggested adding the dual/single interest to charges for ongoing Committee work.


Commissioner Schmidt made a motion, seconded by Commissioner Donelon, to adopt the *Real Property Lender-Placed Insurance Model Act* (#631) (Attachment Two). The motion passed, with California abstaining.


Commissioner Schmidt reported that the Casualty Actuarial and Statistical (C) Task Force was given two charges last year: 1) draft changes to the *Product Filing Review Handbook* to include best practices for the review of predictive models and analytics filed by insurers to justify rates; and 2) draft guidance for the review of state rate filings based on complex predictive models. The Task Force drafted the white paper, *Regulatory Review of Predictive Models*. More than 10 state actuaries contributed to the draft. There were many public exposures of the paper, and it was adopted by the Task Force in fall 2020 and adopted by the Property and Casualty Insurance (C) Committee on Dec. 8, 2020.

As an overview, the *Regulatory Review of Predictive Models* white paper: 1) describes best practices for regulatory review of generalized linear models (GLMs), which is the most often filed model, for the private auto and home lines of business; and 2) provides changes to the *Product Filing Review Handbook* to include best practices for review of predictive models and analytics filed by insurers to justify rates.

The Task Force developed best practices for the review of any model, line of business and insurance application. At the highest level, the best practices are: 1) ensure compliance with current rating laws; 2) review all aspects of the model, including input, assumptions, adjustments and output; 3) evaluate how the model interacts with and improves the rating plan; and 4) enable competition and innovation in the rate review process.

In addition to the best practices, there is detail attached to the paper as Appendix B—Information Elements and Guidance for a Regulator to Meet Best Practices’ Objectives (When Reviewing GLMs). Commissioner Schmidt said this section could be useful to a state insurance regulator when reviewing a rating plan based on a GLM. Additionally, there is commentary on what might be important about that information and some insight as to when the information might identify an issue the state insurance regulator needs to be aware of or explore further.

Commissioner Schmidt made a motion, seconded by Commissioner Ommen, to adopt the *Regulatory Review of Predictive Models* white paper (Attachment Three). The motion passed.

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

Commissioner Richardson reported the Market Regulation and Consumer Affairs (D) Committee met April 13. During this meeting, the Committee took the following action: 1) adopted its 2020 Fall National Meeting minutes; 2) adopted revisions to the Market Conduct Annual Statement (MCAS) Best Practices Guide; 3) adopted revisions to the four market analysis chapters of the *Market Regulation Handbook*; 4) adopted a 14 calendar-day limitation on MCAS filing extension requests; and 5) adopted a requirement for companies to identify MCAS filing attesters by both line of business and by state. This will be implemented for the 2021 data to be reported in 2022.
The Committee heard a presentation on lead generators and improper marketing of health insurance. These issues have been monitored by a broad consortium of state insurance regulators with expertise in antifraud, market conduct and health insurance. The Antifraud (D) Task Force will discuss potential next steps on this issue.

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

10. **Adopted the Amendments to the Antifraud Plan Guideline (#1690)**

Commissioner Richardson reported that during the 2020 Fall National Meeting, the Market Regulation and Consumer Affairs (D) Committee adopted revisions to the Antifraud Plan Guideline (#1690). This effort was led by Commissioner Navarro, chair of the Antifraud (D) Task Force.

Commissioner Navarro reported the focus was to reorganize the guideline into a more intuitive order, to eliminate repetitive requirements and to add suggestions to better meet existing requirements in place in most states. Most of the language in the guideline was not changed but simply rearranged to simplify the process. A comprehensive narrative was added to explain the guideline is not mandated in all states but is considered a best practice. The guideline covers the application, definitions, creation and submission of an antifraud plan to the states, the regulatory requirements for an insurance company to create an antifraud plan, and confidentiality protection for a company’s antifraud plan.

The revised guideline was adopted by the Antifraud (D) Task Force on Nov. 16, 2020 and adopted by the Market Regulation and Consumer Affairs (D) Committee during the 2020 Fall National Meeting.

Commissioner Navarro made a motion, seconded by Commissioner Clark, to adopt the amendments to the Antifraud Plan Guideline (#1690) (Attachment Four). The motion passed.

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

Commissioner White reported that the Financial Condition (E) Committee met April 13 and adopted its March 8, 2021, and 2020 Fall National Meeting minutes, which included the following action: 1) adopted a request for extension of time for model law development from the Mortgage Guaranty Insurance (E) Working Group; 2) adopted a new charge for the Qualified Jurisdiction (E) Working Group and repositioned the Working Group to report directly to the Committee [The Qualified-Mutual Recognition of Jurisdictions (E) Working Group will: develop a process for evaluating jurisdictions that meets the NAIC requirements for recognizing and accepting the NAIC group capital calculation (GCC)]; and 3) adopted proposed recommendations to the Financial Regulation Standards and Accreditation (F) Committee with respect to the GCC and the liquidity stress test (LST).

The Committee adopted the reports of the following task forces and working groups: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Examination Oversight (E) Task Force; Financial Stability (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention Group (E) Task Force; Valuation of Securities (E) Task Force; Group Capital Calculation (E) Working Group; Group Solvency Issues (E) Working Group; Mortgage Guaranty Insurance (E) Working Group; and National Treatment and Coordination (E) Working Group. The report of the National Treatment and Coordination (E) Working Group included disbanding the Biographical Third-Party Review (E) Subgroup.

The Committee adopted changes to the Statement of Statutory Accounting Principles (SSAP) No. 71—Policy Acquisition Costs and Commissions.

The Committee appointed the new Receiver’s Handbook (E) Subgroup and adopted the following related charge: Review the Receiver’s Handbook for Insurance Company Insolvencies (Receiver’s Handbook) to identify areas where information is outdated, updates are required, or additional guidance is needed. Based on this review, draft and propose recommended edits to the Receiver’s Handbook. Complete by the 2022 Fall National Meeting.
Note: Items adopted within the Financial Condition (E) Committee’s task force and working group reports that are considered technical, non-controversial and not significant by NAIC standards—i.e., they do not include model laws, model regulations, model guidelines, or items considered to be controversial—will be considered for adoption by the Executive (EX) Committee and Plenary through the Financial Condition (E) Committee’s technical changes report process. Pursuant to this process, which was adopted by the NAIC in 2009, a listing of the various technical changes will be sent to the NAIC members shortly after completion of the Summer National Meeting, and the members will have 10 days to comment with respect to those items. If no objections are received with respect to a particular item, the technical changes will be considered adopted by the NAIC membership and effective immediately.

12. Adopted the Guideline for Administration of Large Deductible Policies in Receivership (#1980)

Commissioner White reported that, in 2016, the Property and Casualty Insurance (C) Committee published the Workers’ Compensation Large Deductible Study. It was also suggested the Receivership and Insolvency (E) Task Force consider developing possible enhancements to the U.S. receivership regime with regard to large deductible policies. As the work was taken up, a dozen or so states had already adopted variations of model language proposed by the National Conference of Insurance Guaranty Funds (NCIGF) on the topic. This NAIC guideline follows similar principles as the NCIGF model, but the Task Force believes it is an improvement on prior versions of the NCIGF model.

Commissioner White said the states may choose to keep their existing large deductible language or update it with the new guideline. The Task Force strongly encouraged the states that do not currently have a receivership provision that addresses large deductible policies to consider adopting this guideline.

Commissioner White made a motion, seconded by Commissioner Afable, to adopt the Guideline for Administration of Large Deductible Policies in Receivership (#1980) (Attachment Five). The motion passed.

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

Superintendent Dwyer reported that the Financial Regulation Standards and Accreditation (F) Committee met April 8 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, to: 1) discuss state-specific accreditation issues; and 2) vote to award continued accreditation to the insurance departments of New Mexico and Tennessee.

The Committee also met April 12 in open session and adopted its 2020 Fall National Meeting minutes.

The Committee adopted, immediately by reference, revisions made during 2020 to NAIC publications that are required for accreditation purposes (e.g., the Accounting Practices and Procedures Manual [AP&P Manual]) that were deemed insignificant.

The Committee exposed the proposed revisions to the Part A: Laws and Regulations Preamble for a 30-day public comment period ending May 13. The proposed revisions update the XXX/AXXX Captive Reinsurance Framework references to the Term and Universal Life Insurance Reserve Financing Model Regulation (#787), which is effective for accreditation Sept. 1, 2022.

The Committee exposed the 2020 revisions to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) for a 30-day public comment period ending May 13, with the recommendation that the revisions will be effective for all states beginning Jan. 1, 2026. The revisions implement a Group Capital Calculation (GCC) for the purpose of group solvency supervision and a Liquidity Stress Test (LST) for macroprudential surveillance.

The Committee encourages all states with a group impacted by the “Bilateral Agreement between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” and a substantially similar agreement between the United States and the United Kingdom (together, the Covered Agreements) to enact the GCC revisions to Model #440 and Model #450 for those groups, effective Nov. 7, 2022. The Committee also strongly encourages all states with a group impacted by the LST to enact the relevant revisions to Model #440 and Model #450 as soon as possible.
14. Received the Report of the International Insurance Relations (G) Committee

Commissioner Anderson reported that the International Insurance Relations (G) Committee met April 7 and adopted its March 25, 2021; Feb. 3, 2021; Jan. 6, 2021; and 2020 Fall National Meeting minutes, which included the following action: 1) approved submission of NAIC comments on the IAIS draft Application Paper on Supervision of Control Functions; 2) approved submission of NAIC comments on the IAIS draft Application Paper on Resolution Powers and Planning and Consultation on the Development of Liquidity Metrics; 3) approved submission of NAIC comments on the joint Sustainable Insurance Forum (SIF) and IAIS draft Application Paper on the Supervision of Climate-Related Risks in the Insurance Sector.

The Committee heard an update on key 2021 projects and priorities of the IAIS, including: 1) implementation assessment activities related to the holistic framework for systemic risk; 2) the ongoing ICS monitoring period and expected timeline; 3) activities and priorities related to climate risk and sustainability; and 4) the ongoing global impact of COVID-19 on supervisors and the insurance sector.

The Committee heard a presentation on scalar methodologies from the American Academy of Actuaries (Academy).

The Committee heard an update on international activities, including recent virtual meetings and events with international colleagues; plans for a virtual spring 2021 NAIC International Fellows Program; recent meetings of the OECD Insurance and Private Pensions Committee and Environment Directorate; recent meetings of the SIF and other regional supervisory dialogues; and the May 25–26 virtual 2021 NAIC International Insurance Forum.

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

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

Having no further business, the Executive (EX) Committee and Plenary adjourned.
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

1. Name of group to be responsible for drafting the model:
   Innovation and Technology (EX) Task Force

2. NAIC staff support contact information:
   Denise Matthews
dmatthews@naic.org
816-783-8007

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

   NAIC Unfair Trade Practices Act (Model #880)
   Section 4(H)(1)

   The Innovation and Technology (EX) Task Force will draft amendments to the NAIC Unfair Trade Practices Act (Model #880), focusing on Section 4H, to clarify what is considered a “rebate” or “inducement”.

4. Does the model law meet the Model Law Criteria? X Yes or □ No (Check one)
   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

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

      If yes, please explain why: Inconsistency in the interpretation of the Model language necessitates revisions to clarify the intent and ensure necessary consumer protections remain in place in light of technologies being deployed to add value to existing insurance products and services.

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

      X Yes or □ No (Check one)
5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

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Explanation, if necessary: A significant amount of time and discussion has already been devoted to this topic including presentations from all stakeholders and discussion around draft guideline language. That should help in accelerating the development process related to this model language.

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

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Explanation, if necessary:

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

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Explanation, if necessary:

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

No

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

No.
UNFAIR TRADE PRACTICES ACT

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Section 4. Unfair Trade Practices Defined

Any of the following practices, if committed in violation of Section 3, are hereby defined as unfair trade practices in the business of insurance:

A. Misrepresentations and False Advertising of Insurance Policies. Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison that:

(1) Misrepresents the benefits, advantages, conditions or terms of any policy; or
(2) Misrepresents the dividends or share of the surplus to be received on any policy; or
(3) Makes a false or misleading statement as to the dividends or share of surplus previously paid on any policy; or
(4) Is misleading or is a misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates; or
(5) Uses any name or title of any policy or class of policies misrepresenting the true nature thereof; or
(6) Is a misrepresentation, including any intentional misquote of premium rate, for the purpose of inducing or tending to induce the purchase, lapse, forfeiture, exchange, conversion or surrender of any policy; or
(7) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any policy; or
(8) Misrepresents any policy as being shares of stock.
B. False Information and Advertising Generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any insurer in the conduct of its insurance business, which is untrue, deceptive or misleading.

C. Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any insurer, and which is calculated to injure such insurer.

D. Boycott, Coercion and Intimidation. Entering into any agreement to commit, or by any concerted action committing any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

E. False Statements and Entries.

(1) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of an insurer.

(2) Knowingly making any false entry of a material fact in any book, report or statement of any insurer or knowingly omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer, or knowingly making any false material statement to any insurance department official.

F. Stock Operations and Advisory Board Contracts. Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to purchase insurance.

G. Unfair Discrimination.

(1) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any life insurance policy or annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such policy.

(2) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any accident or health insurance policy or in the benefits payable thereunder, or in any of the terms or conditions of such policy, or in any other manner.

Drafting Note: In the event that unfair discrimination in connection with accident and health coverage is treated in other statutes, this paragraph should be omitted.

(3) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazard by refusing to insure, refusing to renew, canceling or limiting the amount of insurance coverage on a property or casualty risk solely because of the geographic location of the risk, unless such action is the result of the application of sound underwriting and actuarial principles related to actual or reasonably anticipated loss experience.
(4) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to insure, refusing to renew, canceling or limiting the amount of insurance coverage on the residential property risk, or the personal property contained therein, solely because of the age of the residential property.

(5) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the sex, marital status, race, religion or national origin of the individual; however, nothing in this subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits. Nothing in this section shall prohibit or limit the operation of fraternal benefit societies.

(6) To terminate, or to modify coverage or to refuse to issue or refuse to renew any property or casualty policy solely because the applicant or insured or any employee of either is mentally or physically impaired; provided that this subsection shall not apply to accident and health insurance sold by a casualty insurer and, provided further, that this subsection shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance or renewal of any insurance policy or contract.

(7) Refusing to insure solely because another insurer has refused to write a policy, or has cancelled or has refused to renew an existing policy in which that person was the named insured. Nothing herein contained shall prevent the termination of an excess insurance policy on account of the failure of the insured to maintain any required underlying insurance.

(8) Violation of the state’s rescission laws at [insert reference to appropriate code section].

Drafting Note: A state may wish to include this section if it has existing state laws covering rescission and to insert a reference to a particular code section.

H. Rebates.

(1) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any life insurance policy or annuity, or accident and health insurance or other insurance, or agreement as to such contract other than as plainly expressed in the policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such policy, any rebate of premiums payable on the policy, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the policy; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such policy or annuity or in connection therewith, any stocks, bonds or other securities of any company or other corporation, association or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the policy.

(2) Nothing in Subsection G, or Paragraph (1) of Subsection H shall be construed as including within the definition of discrimination or rebates any of the following practices:

(a) In the case of life insurance policies or annuities, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(b) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount that fairly represents the saving in collection expenses;
(c) Readjusting the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year; or


(e) The offer or provision by insurers or producers, by or through employees, affiliates or third party representatives, of value-added products or services at no or reduced cost when such products or services are not specified in the policy of insurance if the product or service:

(i) Relates to the insurance coverage; and

(ii) Is primarily designed to satisfy one or more of the following:

(I) Provide loss mitigation or loss control;

(II) Reduce claim costs or claim settlement costs;

(III) Provide education about liability risks or risk of loss to persons or property;

(IV) Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk;

(V) Enhance health;

(VI) Enhance financial wellness through items such as education or financial planning services;

(VII) Provide post-loss services;

(VIII) Incent behavioral changes to improve the health or reduce the risk of death or disability of a customer (defined for purposes of this subsection as policyholder, potential policyholder, certificate holder, potential certificate holder, insured, potential insured or applicant); or

(IX) Assist in the administration of the employee or retiree benefit insurance coverage.

(iii) The cost to the insurer or producer offering the product or service to any given customer must be reasonable in comparison to that customer’s premiums or insurance coverage for the policy class.

(iv) If the insurer or producer is providing the product or service offered, the insurer or producer must ensure that the customer is provided with contact information to assist the customer with questions regarding the product or service.
v) The commissioner may adopt regulations when implementing the permitted practices set forth in this statute to ensure consumer protection. Such regulations, consistent with applicable law, may address, among other issues, consumer data protections and privacy, consumer disclosure and unfair discrimination.

vi) The availability of the value-added product or service must be based on documented objective criteria and offered in a manner that is not unfairly discriminatory. The documented criteria must be maintained by the insurer or producer and produced upon request by the Department.

Drafting Note: States may wish to consider alternative language based on their filing requirements.

vii) If an insurer or producer does not have sufficient evidence, but has a good-faith belief that the product or service meets the criteria in H(2)(e)(ii), the insurer or producer may provide the product or service in a manner that is not unfairly discriminatory as part of a pilot or testing program for no more than one year. An insurer or producer must notify the Department of such a pilot or testing program offered to consumers in this state prior to launching and may proceed with the program unless the Department objects within twenty-one days of notice.

Drafting Note: This Section is not intended to limit or curtail existing value-added services in the marketplace. It is intended to promote innovation in connection with the offering of value-added services while maintaining strong consumer protections.

(f) An insurer or a producer may:

(i) Offer or give non-cash gifts, items, or services, including meals to or charitable donations on behalf of a customer, in connection with the marketing, sale, purchase, or retention of contracts of insurance, as long as the cost does not exceed an amount determined to be reasonable by the commissioner per policy year per term. The offer must be made in a manner that is not unfairly discriminatory. The customer may not be required to purchase, continue to purchase or renew a policy in exchange for the gift, item or service.

(ii) Offer or give non-cash gifts, items, or services including meals to or charitable donations on behalf of a customer, to commercial or institutional customers in connection with the marketing, sale, purchase, or retention of contracts of insurance, as long as the cost is reasonable in comparison to the premium or proposed premium and the cost of the gift or service is not included in any amounts charged to another person or entity. The offer must be made in a manner that is not unfairly discriminatory. The customer may not be required to purchase, continue to purchase or renew a policy in exchange for the gift, item or service.

(iii) Conduct raffles or drawings to the extent permitted by state law, as long as there is no financial cost to entrants to participate, the drawing or raffle does not obligate participants to purchase insurance, the prizes are not valued in excess of a reasonable amount determined by the commissioner and the drawing or raffle is open to the public. The raffle or drawing must be offered in a manner that is not unfairly discriminatory. The customer may not be required to purchase, continue to purchase or renew a policy in exchange for the gift, item or service.
Drafting Note: If a state wishes to limit (f) to a stated monetary limit the committee would suggest that, at the time of the drafting of this model, the lesser of 5% of the current or projected policyholder premium or $250 would be an appropriate limit, however specific prohibitions may exist related to transactions governed by the Real Estate Settlement Procedures Act of 1974 and the laws and regulations governing the Federal Crop Insurance Corporation Risk Management Agency. States may want to consider a limit for commercial or institutional customers.

(3) An insurer, producer or representative of either may not offer or provide insurance as an inducement to the purchase of another policy or otherwise use the words “free”, “no cost” or words of similar import, in an advertisement.

Drafting Note: Section 104 (d)(2)(B)(viii) of the Gramm-Leach-Bliley Act provides that any state restrictions on anti-tying may not prevent a depository institution or affiliate from engaging in any activity that would not violate Section 106 of the Bank Holding Company Act Amendments of 1970, as interpreted by the Board of Governors of the Federal Reserve System. The Board of Governors of the Federal Reserve System has stated that nothing in its interpretation on combined-balance discount arrangements is intended to override any other applicable state and federal law. FRB SR 95-32 (SUP). Section 5(q) of the Home Owners’ Loan Act is the analogous provision to Section 106 for thrift institutions. The Office of Thrift Supervision has a regulation 12 C.F.R. 563.36 that allows combined-balance discounts if certain requirements are met.

Drafting Note: Each state may wish to examine its rating laws to ensure that it contains sufficient provisions against rebating. If a state does not, this section may be expanded to cover all lines of insurance.

I. Prohibited Group Enrollments. No insurer shall offer more than one group policy of insurance through any person unless such person is licensed, at a minimum, as a limited insurance representative. However, this prohibition shall not apply to employer/employee relationships, nor to any such enrollments.

J. Failure to Maintain Marketing and Performance Records. Failure of an insurer to maintain its books, records, documents and other business records in such an order that data regarding complaints, claims, rating, underwriting and marketing are accessible and retrievable for examination by the insurance commissioner. Data for at least the current calendar year and the two (2) preceding years shall be maintained.

K. Failure to Maintain Complaint Handling Procedures. Failure of any insurer to maintain a complete record of all the complaints it received since the date of its last examination under Section [insert applicable section]. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this subsection, “complaint” shall mean any written communication primarily expressing a grievance.

L. Misrepresentation in Insurance Applications. Making false or fraudulent statements or representations on or relative to an application for a policy, for the purpose of obtaining a fee, commission, money or other benefit from any provider or individual person.

M. Unfair Financial Planning Practices. An insurance producer:

(1) Holding himself or herself out, directly or indirectly, to the public as a “financial planner,” “investment adviser,” “consultant,” “financial counselor,” or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters or trust and estate matters when such person is in fact engaged only in the sale of policies. This provision does not preclude persons who hold some form of formal recognized financial planning or consultant certification or designation from using this certification or designation when they are only selling insurance. This does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.
(2) (a) Engaging in the business of financial planning without disclosing to the client prior to the execution of the agreement provided for in Paragraph 3, or solicitation of the sale of a product or service that

(i) He or she is also an insurance salesperson, and

(ii) That a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case.

(b) The disclosure requirement under this subsection may be met by including it in any disclosure required by federal or state securities law.

(3) (a) Charging fees other than commissions for financial planning by insurance producer, unless such fees are based upon a written agreement, signed by the party to be charged in advance of the performance of the services under the agreement. A copy of the agreement must be provided to the party to be charged at the time the agreement is signed by the party.

(i) The services for which the fee is to be charged must be specifically stated in the agreement.

(ii) The amount of the fee to be charged or how it will be determined or calculated must be specifically stated in the agreement.

(iii) The agreement must state that the client is under no obligation to purchase any insurance product through the insurance producer or consultant.

Drafting Note: This subsection is intended to apply only to persons engaged in personal financial planning.

(b) The insurance producer shall retain a copy of the agreement for not less than three (3) years after completion of services, and a copy shall be available to the commissioner upon request.

N. Failure to file or to certify information regarding the endorsement or sale of long-term care insurance. Failure of any insurer to:

(1) File with the insurance department the following material:

(a) The policy and certificate;

(b) A corresponding outline of coverage; and

(c) All advertisements requested by the insurance department; or

(2) Certify annually that the association has complied with the responsibilities for disclosure, advertising, compensation arrangements, or other information required by the commissioner, as set forth by regulation.

O. Failure to Provide Claims History

(1) Loss Information—Property and Casualty. Failure of a company issuing property and casualty insurance to provide the following loss information for the three (3) previous policy years to the first named insured within thirty (30) days of receipt of the first named insured’s written request:

(a) On all claims, date and description of occurrence, and total amount of payments; and
(b) For any occurrence not included in Subparagraph (a) of this paragraph, the date and description of occurrence.

(2) Should the first named insured be requested by a prospective insurer to provide detailed loss information in addition to that required under Paragraph (1), the first named insured may mail or deliver a written request to the insurer for the additional information. No prospective insurer shall request more detailed loss information than reasonably required to underwrite the same line or class of insurance. The insurer shall provide information under this subparagraph to the first named insured as soon as possible, but in no event later than twenty (20) days of receipt of the written request. Notwithstanding any other provision of this section, no insurer shall be required to provide loss reserve information, and no prospective insurer may refuse to insure an applicant solely because the prospective insurer is unable to obtain loss reserve information.

(3) The commissioner may promulgate regulations to exclude the providing of the loss information as outlined in Paragraph (1) for any line or class of insurance where it can be shown that the information is not needed for that line or class of insurance, or where the provision of loss information otherwise is required by law.

Drafting Note: Loss information on workers’ compensation is an example in some states of loss information otherwise required by law.

(4) Information provided under Paragraph (2) shall not be subject to discovery by any party other than the insured, the insurer and the prospective insurer.

Drafting Note: This provision may not be required in states that have a privacy act that governs consumer access to this information. Those states considering applying this requirement to life, accident and health lines of insurance should first review their state privacy act related to issues of confidentiality of individual insured information.

P. Violating any one of Sections [insert applicable sections].

Drafting Note: Insert section numbers of any other sections of the state’s insurance laws deemed desirable or necessary to include as an unfair trade practice, such as cancellation and nonrenewal laws.
PROJECT HISTORY

UNFAIR TRADE PRACTICES ACT #880

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

The NAIC’s Innovation and Technology (EX) Task Force began discussing rebating issues in 2018 during the NAIC Summer National Meeting in Boston, MA, particularly because of the increased interest in offering value-added products and services such as risk mitigation devices and related services that are not necessarily addressed within the applicable insurance policy language. After finding that state interpretation and application of anti-rebating laws varies and after reviewing the history of the NAIC’s Unfair Trade Practices Act (#880) along with the history and the intent of the anti-rebating portion, it became clear that applying the anti-rebating laws to the innovation of new insurance products and services could be challenging. The Task Force received presentations and testimony from many stakeholders, including state insurance regulators, producers, consumers, insurance companies and the startup community regarding a wide array of opinions and concerns. They also offered various suggestions for improving uniform application of anti-rebating statutes in the states. Based on this research and hearing from stakeholders, the Task Force members determined it would be appropriate to review Model #880, specifically Section 4(H)(2).

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

The Innovation and Technology (EX) Task Force was responsible for the drafting of the revisions to Model #880. The process began with the formation of a drafting group. The group was led by Superintendent Elizabeth Kelleher Dwyer (RI). Seven other states participated in the drafting process: Alaska, Alabama, Iowa, Missouri, North Dakota, Ohio and Washington. Also participating were six industry representatives, including one startup; one state legislator (Rep. Matt Lehman (IN), the president of National Council of Insurance Legislators—NCOIL); and a consumer representative.

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

The mission of the Innovation and Technology (EX) Task Force is to: 1) provide a forum for state insurance regulator education and discussion of innovation and technology in the insurance sector; 2) monitor technology developments that affect the state insurance regulatory framework; and 3) develop regulatory guidance, as appropriate. This work was done under the specific charge:

The Innovation and Technology (EX) Task Force will:
Develop regulatory guidance, model laws or model law revisions, and white papers or make other recommendations to the Executive (EX) Committee, as appropriate.

At its meeting during the 2019 Summer National Meeting, the Task Force voted to move forward with the Request for NAIC Model Law Development to open Model #880 to amend or add to the language in Section 4(H)(2). The request was adopted by the Task Force in October 2019 and subsequently by the NAIC Executive (EX) Committee in December during the 2019 Fall National meeting.

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

The drafting group met twice at the beginning of 2020, in January and February, and then stopped meeting for a period of time because of the COVID-19 pandemic. However, it regrouped to meet two more times in May and June. Given the Task Force had already received considerable input from stakeholders regarding this topic, the drafting group was able to move forward expeditiously and disbanded prior to the 2020 Summer National Meeting.
5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The first draft published out of the drafting group was posted for comment on June 23. Twenty-one comment letters were submitted, and Superintendent Dwyer reviewed the changes made based on those comments during the Task Force’s meeting on Aug. 7. A new draft was posted and exposed for comment on Aug. 10. Seventeen comments were reviewed, and a new draft was posted on Oct. 30. During the Task Force’s meeting on Nov. 4, Superintendent Dwyer again reviewed each substantive comment, noting whether it was accepted or rejected in the latest draft. Comments regarding the Oct. 30 draft were again requested and accepted. Seven comments were reviewed, and interested parties were given an opportunity to present their points orally. Additionally, Task Force members and interested parties had the opportunity to ask questions or pose challenges to those points during a meeting on Nov. 30. Five presentations were made. Following the meeting on Nov. 30, another draft was posted on Dec. 2. During its meeting on Dec. 4 and with 44 members of the Task Force in attendance, the revised language was adopted, with Nevada dissenting and California, Hawaii, Idaho and New Jersey abstaining.

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

While the genesis for drafting this revised language was primarily the need to clarify intentions related to the acceptability of the offering of things of value in the best interests of the consumer and to mitigate risk associated with what is being underwritten, value-added products and services, Section H(2)(e), the group also took on drafting clarifying language related to producer and insurer marketing including non-cash gifts meals, charitable donations on behalf of a customer, raffles and drawings, Section H(2)(f).

Since the term “value-added” is relatively new, there was considerable discussion regarding its use. Ultimately, the drafters and most of the state insurance regulators and interested parties agreed it was the appropriate term and needed no further defining.

There was considerable debate and discussion regarding the list in Section H(2)(e)(ii). The term “primarily designed” was discussed very thoroughly as the early use of the term “primarily intended” gave some state insurance regulators concern given the difficulty in determining “intent.” There seemed to be consensus that “designed” was a much better term to use in this case. The list itself was heavily debated both in terms of it being comprehensive and there not being a “catch-all,” as well as in terms of the value-added product or service needing to satisfy at least one of the listed criteria.

The cost discussed in Section H(2)(e)(iii) was also heavily debated. In the end, in addition to other language in that section, it was determined to be appropriate to include a drafting note that notes states may consider alternative language depending on their filing requirements. There was great care given to there being deference or to acknowledging some states may already have statute or regulation language that addresses or sets out permitted practices.

There was also a lot of discussion regarding Section H(2)(e)(vii). The debate was primarily around differences of opinion regarding whether offering the value-added product or service would need to be preapproved by the Department of Insurance (DOI). The concern on the part of industry was slowing down the ability to move forward with a pilot or testing something new, which led, ultimately, to the decision to require notification to the DOI, with a 21-day time period for the DOI to object.

In Section H(2)(f), great care was given to the specific terms used in this section. Given the history with this issue specific to the dollar amount, a drafting note was included to offer a suggested monetary amount but ultimately left to the state. In addition, this section addresses commercial or institutional customers as there was a great deal of discussion around excluding commercial lines from this section altogether, considering the notion that a transaction between sophisticated purchasers and sellers does not require this type of oversight.

Lastly, Section H(3) is intended to make clear that original rebating language intended to prevent abuses related to inducement to purchase or renew is still in effect, and this new language should not be construed to change that.
7. List the key provisions of the model (sections considered most essential to state adoption)

Section H(2)(e), Section H(2)(f) and Section H(3)

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

No other items are identified at this time.
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

1. Name of group to be responsible for drafting the model:
   Creditor-Placed Insurance Model Act Review (C) Working Group

2. NAIC staff support contact information:
   Aaron Brandenburg
   abrandenburg@naic.org
   816-783-8271

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.
   Real Property Lender Placed Insurance Model Act.
   The Creditor-Placed Insurance Model Act Review (C) Working Group has been discussing revisions to the Creditor-Placed Insurance Model Act (#375) which focuses on creditor-placed insurance placed on personal property and auto loans. The Working Group was originally charged with looking at lender-placed insurance on mortgage loans, including reviewing information from hearings and regulatory actions that necessitate changes to the Model Law. The Working Group has determined two separate laws should exist, one for personal property and one for real property. The Working Group would like to work on a new model concerning lender-placed insurance placed on real property mortgage loans, as described in this Model Law Request, and work on Model #375 concerning personal property loans separately.

4. Does the model law meet the Model Law Criteria? ☒ Yes or ☐ No (Check one)
   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).
   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? ☒ Yes or ☐ No (Check one)
      If yes, please explain why – States have taken regulatory action following abuses in the lender-placed insurance market as it relates to homeowners insurance. A consistent regulatory structure is desired to address these issues within the market.
   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?
      ☒ Yes or ☐ No (Check one)
5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

☐ 1 ☒ 2 ☐ 2 ☐ 4 ☐ 5 (Check one)

High Likelihood                 Low Likelihood

Explanation, if necessary: The Working Group has spent over a year hearing from interested parties on issues related to lender-placed insurance as it reviewed Model #375. It has begun drafting language but now feels that issues regarding mortgage loans should be split from issues regarding personal property loans, into two separate models. The Working Group should be able to take the existing work done on the real property discussions related to Model #375 and complete its work on a new Model.

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

☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood                 Low Likelihood

Explanation, if necessary:

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

☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood                 Low Likelihood

Explanation, if necessary: The Working Group feels state legislatures will be more likely to adopt a new model related to real property lender-placed insurance, rather than a model that addresses both personal and real property.

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

No

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

No
NEW MODEL:
Adopted by the Lender-Placed Insurance Model Act (C) Working Group, 11/13/20
Adopted by the Property and Casualty Insurance (C) Committee, 12/8/20

REAL PROPERTY LENDER-PLACED INSURANCE MODEL ACT

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Section 1. Purpose

The purpose of this Act is to:

A. Promote the public welfare by regulating lender-placed insurance on real property.
B. Create a legal framework within which lender-placed insurance on real property may be written in this state.
C. Help maintain the separation between lenders/servicers and insurers/insurance producers.
D. Minimize the possibilities of unfair competitive practices in the sale, placement, solicitation and negotiation of lender-placed insurance.

Section 2. Scope

A. This Act applies to insurers and insurance producers engaged in any transaction involving lender-placed insurance as defined in this Act.
B. All lender-placed insurance written in connection with mortgaged real property, including manufactured and mobile homes, is subject to the provisions of this Act, except:

   (1) Transactions involving extensions of credit primarily for business, commercial or agricultural purposes.
   (2) Insurance offered by the lender or servicer and elected by the mortgagor at the mortgagor’s option.
   (3) Insurance purchased by a lender or servicer on real estate owned property.
   (4) Insurance for which no specific charge is made to the mortgagor or the mortgagor’s account.

Drafting Note: Nothing in this Act shall be construed to create or imply a private cause of action for violation of this Act, and the commissioner shall have authority to enforce this Act subject to the laws of this state. Furthermore, nothing in this Act shall be construed to extinguish any mortgagor rights available under common law or other state statutes.
Section 3. Definitions

As used in this Act:

A. “Affiliate” shall mean a person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the person specified.

B. “Individual lender-placed insurance” means coverage for individual real property evidenced by a certificate of coverage under a master lender-placed insurance policy or a lender-placed insurance policy for individual real property.

C. “Insurance Producer” means a person or entity (or its Affiliates) required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

D. “Insurer” means an insurance company, association or exchange authorized to issue lender-placed insurance in [insert applicable state] (or its Affiliates).

E. “Investor” means a person or entity (and its Affiliates) holding a beneficial interest in loans secured by real property.

F. “Lapse” means the moment in time in which a mortgagor has failed to secure or maintain valid and/or sufficient insurance upon mortgaged real property as required by a mortgage agreement.

G. “Lender” means a person or entity (and its Affiliates) making loans secured by an interest in real property.

H. “Lender-placed insurance” means insurance obtained by a lender or servicer when a mortgagor does not maintain valid and/or sufficient insurance upon mortgaged real property as required by the terms of the mortgage agreement. It may be purchased unilaterally by the lender or servicer, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss, expense or damage to collateralized property as a result of fire, theft, collision or other risks of loss that would either impair a lender, servicer or investor’s interest or adversely affect the value of collateral covered by limited dual interest insurance. It is purchased according to the terms of the mortgage agreement as a result of the mortgagor’s failure to provide evidence of required insurance.

I. “Loss ratio” means the ratio of incurred losses to earned premium.

J. “Master lender-placed insurance policy” means a group policy issued to a lender or servicer providing coverage for all loans in the lender or servicer’s loan portfolio as needed.

K. “Mortgage agreement” means the written document that sets forth an obligation or a liability of any kind secured by a lien on real property and due from, owing or incurred by a mortgagor to a lender on account of a mortgage loan, including the security agreement, Deed of Trust and any other document of similar effect, and any other documents incorporated by reference.

L. “Mortgage loan” means a loan, advance, guarantee or other extension of credit from a lender to a mortgagor.

M. “Mortgage transaction” means a transaction by the terms of which the repayment of money loaned or payment of real property sold is to be made at a future date or dates.

N. “Mortgagee” means the person who holds mortgaged real property as security for repayment of a mortgage agreement.

O. “Mortgagor” means the person who is obligated on a mortgage loan pursuant to a mortgage agreement.

P. “Person” means an individual or entity.
Q. “Real Estate Owned Property” means property owned or held by a lender or servicer following foreclosure under the related Mortgage agreement or the acceptance of a deed in lieu of foreclosure.

R. “Replacement Cost Value (RCV)” is the estimated cost to replace covered property at the time of loss or damage without deduction for depreciation. RCV is not market value, but it is instead the cost to replace covered property to its pre-loss condition.

S. “Servicer” means a person or entity (and its Affiliates) contractually obligated to service one or more mortgage loans for a Lender or Investor. The term “Servicer” includes entities involved in subservicing arrangements.

Section 4. Term of Insurance Policy

A. Lender-placed insurance shall become effective no earlier than the date of lapse of insurance upon mortgaged real property subject to the terms of a mortgage agreement and/or any other state or federal law requiring the same.

B. Individual lender-placed insurance shall terminate on the earliest of the following dates:

1. The date insurance that is acceptable under the mortgage agreement becomes effective, subject to the mortgagor providing sufficient evidence of such acceptable insurance.

2. The date the applicable real property no longer serves as collateral for a mortgage loan pursuant to a mortgage agreement.

3. Such other date as specified by the individual policy or certificate of insurance.

4. Such other date as specified by the lender or servicer.

5. The termination date of the policy.

C. An insurance charge shall not be made to a mortgagor for lender-placed insurance for a term longer than the scheduled term of the lender-placed insurance, nor may an insurance charge be made to the mortgagor for lender-placed insurance before the effective date of the lender-placed insurance.

Section 5. Calculation of Coverage and Payment of Premiums

A. Any lender-placed insurance coverage, and subsequent calculation of premium, should be based upon the replacement cost value of the property as best determined as follows:

1. The dwelling coverage amount set forth in the most recent evidence of insurance coverage provided by the mortgagee (“last known coverage amount” or “LKCA”), if known to the lender or servicer.

2. The insurer shall inquire of the insured, at least once, as to the LKCA; and if it is not able to obtain the LKCA from the insured or in another manner, the insurer may proceed as set forth below.

3. If the LKCA is unknown, the replacement cost of the property serving as collateral as calculated by the insurer, unless the use of replacement cost for this purpose is prohibited by other state or federal law.

4. If the LKCA is unknown and the replacement cost is not available or its use is prohibited, the unpaid principal balance of the mortgage loan.

B. In the event of a covered loss, any replacement cost coverage provided by an insurer in excess of the unpaid principal balance of the mortgage loan shall be paid to the mortgagor.

C. An insurer shall not write lender-placed insurance for which the premium rate differs from that determined by the schedules of the insurer on file with the commissioner as of the effective date of any such policy.
Section 6. Prohibited Practices

A. An insurer or insurance producer shall not issue lender-placed insurance on mortgaged property that the insurer or insurance producer or an Affiliate of the insurer or insurance producer owns, performs the servicing for, or owns the servicing right to the mortgaged property.

B. An insurer or insurance producer shall not compensate a lender, insurer, investor or servicer (including through the payment of commissions) on lender-placed property insurance policies issued by the insurer.

C. An insurer or insurance producer shall not share lender-placed insurance premium or risk with the lender, investor or servicer that obtained the lender-placed insurance.

D. An insurer or insurance producer shall not offer contingent commissions, profit sharing, or other payments dependent on profitability or loss ratios to any person affiliated with a servicer or the insurer in connection with lender-placed insurance.

E. An insurer shall not provide free or below-cost outsourced services to lenders, investors or servicers, and an insurer will not outsource its own functions to lenders, insurance producers, investors or servicers on an above-cost basis.

F. An insurer or insurance producer shall not make any payments, including but not limited to the payment of expenses to a lender, insurer, investor or servicer for the purpose of securing lender-placed insurance business or related outsourced services.

Section 7. Non-Circumvention

Nothing in this Act shall be construed to allow an insurance producer or an insurer solely underwriting lender-placed insurance to circumvent the requirements set forth within this Act. Any such part of any requirements, limitations or exclusions provided herein apply in any part to any insurer or insurance producer involved in lender-placed insurance.

Section 8. Evidence of Coverage

Lender-placed insurance shall be set forth in an individual policy or certificate of insurance. A copy of the individual policy, certificate of insurance, or other evidence of insurance coverage shall be mailed, first class mailed, or delivered in person to the last known address of the mortgagor or delivered in accordance with [inset reference to Electronic Transaction Act]. Notwithstanding any other statutory or regulatory required information, the individual policy or certificate of insurance coverage shall include the following information:

A. The address and identification of the insured property.

B. The coverage amount or amounts if multiple coverages are provided.

C. The effective date of the coverage.

D. The term of coverage.

E. The premium charge for the coverage.

F. Contact information for filing a claim.

G. A complete description of the coverage provided.

Section 9. Filing, Approval and Withdrawal of Forms and Rates

A. All policy forms and certificates of insurance to be delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the Commissioner.
B. The Commissioner shall review the rates to determine whether the rates are excessive, inadequate or unfairly discriminatory. This analysis shall include a determination as to whether expenses included by the insurer in the rate are appropriate.

C. All insurers shall re-file lender-placed property insurance rates at least once every four (4) years.

D. All insurers writing lender-placed insurance shall have separate rates for lender-placed insurance and voluntary insurance obtained by a mortgage servicer on real estate owned property.

E. Upon the introduction of a new lender-placed insurance program, the insurer shall reference its experience in existing programs in the associated filings. Nothing in this Act shall limit an insurer’s discretion, as actuarially appropriate, to distinguish different terms, conditions, exclusions, eligibility criteria or other unique or different characteristics. Moreover, an insurer may, where actuarially acceptable, rely upon models or, in the case of flood filings where applicable experience is not credible, on Federal Emergency Management Agency (FEMA) National Flood Insurance Program (NFIP) data.

F. No later than April 1 of each year, each insurer with at least $100,000 in direct written premium for lender-placed insurance in this state during the prior calendar year shall report to the Commissioner the following information for the prior calendar year:

   (1) Actual loss ratio.
   (2) Earned premium.
   (3) Any aggregate schedule rating debit/credit to earned premium.
   (4) Itemized expenses.
   (5) Paid losses.
   (6) Loss reserves, including case reserves and reserves for incurred but not reported losses.

This report shall be separately produced for each lender-placed program and presented on both an individual-jurisdiction and countrywide basis.

G. Except in the case of lender-placed flood insurance, to which this paragraph does not apply, if an insurer experiences an annual loss ratio of less than 35% in any lender-placed program for two consecutive years, it shall submit a rate filing (either adjusting its rates or supporting their continuance) to the Commissioner no more than 90 days after the submission of the data required in F. above.

Drafting Note: The 35% trigger for re-filing rates is not intended to be, nor should be interpreted as, a loss ratio standard for determining whether rates are excessive or inadequate. The loss ratio standard in this section is solely directed to prompt a re-filing of rates by the insurer.

H. Except as specifically set forth in this Section, rate and form filing requirements shall be subject to the insurance laws of this state.

Section 10. Enforcement

The Commissioner shall have all rights and powers to enforce the provisions of this Act as provided by section(s) [insert section(s) number] of the Insurance Code of this state.

Section 11. Regulatory Authority

The commissioner may, after notice and hearing, promulgate reasonable regulations and orders to carry out and effectuate the provisions of this Act.
Section 12. Judicial Review

A. A person subject to an order or final determination of the commissioner under Section 8 or Section 13 may obtain a review of the order or final determination by filing in the [insert title] Court of [insert county] County, within [insert number] days from the date of the service of the order, a written petition praying that the order of the commissioner be set aside. A copy of the petition shall be served upon the commissioner, and the commissioner shall certify and file in the court a transcript of the entire record in the proceeding, including all the evidence taken and the report and order or final determination of the commissioner. Upon filing of the petition and transcript, the court shall have jurisdiction of the proceeding; and the questions determined shall determine whether the filing of the petition shall operate as a stay of the order or final determination of the commissioner, and they shall have power to make and enter upon the pleadings, evidence and proceedings set forth in the transcript a decree modifying, affirming or reversing the order or final determination of the commissioner, in whole or in part. The findings of the commissioner as to the facts, if supported by [insert type] evidence, shall be conclusive.

Drafting Note: Insert appropriate language to accommodate to local procedure the effect given the commissioner’s determination.

B. To the extent that the order or final determination of the commissioner is affirmed, the court shall issue its own order commanding obedience to the terms of the order or final determination of the commissioner. If either party applies to the court for leave to adduce additional evidence and shows to the satisfaction of the court that the additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the commissioner, the court may order the additional evidence to be taken before the commissioner and be adduced upon the hearing in the manner and upon the terms and conditions the court may deem proper. The commissioner may modify the findings of fact, or make new findings by reason of the additional evidence so taken, and shall file such modified or new findings that are supported by [insert type] evidence with a recommendation if any, for the modification or setting aside of the original order or final determination, with the return of the additional evidence.

Drafting Note: Insert appropriate language to accommodate to local procedure the effect given the commissioner’s determination. In a state where final judgment, order or final determination or decree would not be subject to review by an appellate court, provision should therefore be inserted here.

C. An order issued by the commissioner under Section 13 shall become final:

(1) Upon the expiration of the time allowed for filing a petition for review if no petition has been duly filed within that time except that the commissioner may thereafter modify or set aside the order to the extent provided in Section 13.

(2) Upon the final decision of the court if the court directs that the order of the commissioner be affirmed or the petition for review be dismissed.

D. No order of the commissioner under this Act or order of a court to enforce the same shall relieve or absolve any person affected by the order from liability under any other laws of this state.

Drafting Note: States may delete this section if the substance of it already exists in state law.

Section 13. Penalties

An insurer that violates an order of the commissioner while the order is in effect may, after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to either or both of the following:

A. Payment of a monetary penalty of not more than $1,000 for each violation, but not to exceed an aggregate penalty of $100,000, unless the violation was committed flagrantly in a conscious disregard of this Act, in which case the penalty shall not be more than $25,000 for each violation, but not to exceed an aggregate penalty of $250,000.
B. Suspension or revocation of the insurer’s license.

Drafting Note: States may delete or modify this section if the substance of it already exists in state law.


If any provision of this Act, or the application of the provision to any person or circumstance, is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 15. Effective Date

This Act shall take effect [insert effective date].
PROJECT HISTORY

REAL PROPERTY LENDER-PLACED INSURANCE MODEL ACT

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

The Creditor-Placed Insurance Model Act Review (C) Working Group was appointed in May 2015 with a charge to review information from a 2012 public hearing on lender-placed insurance (LPI) and determine if changes were needed to the Creditor-Placed Insurance Model Act (#375) having to do with creditor-placed automobile insurance. The Working Group met throughout 2015, 2016 and 2017 to review a New York regulation and Florida orders concerning LPI. In 2017, the Working Group began discussing the need to split the topics of personal property and real property into two different sections or two different models. In July 2017, the Working Group decided it would need to split the personal property from real property into two different models, and the Property and Casualty Insurance (C) Committee adopted a Request for NAIC Model Law Development on July 18, 2017.

In 2018, the Property and Casualty Insurance (C) Committee appointed the Lender-Placed Insurance Model Act (C) Working Group to only focus on drafting a new model related to lender-placed homeowners’ insurance.

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

The 2020 members of the Lender-Placed Insurance Model Act (C) Working Group were: Florida (Chair), Rhode Island (Vice Chair), Alaska, California, Connecticut, District of Columbia, Louisiana, Mississippi, North Dakota, Oklahoma, Texas, Virginia and Wisconsin.

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

On July 18, 2017, the Property and Casualty Insurance (C) Committee adopted a Request for NAIC Model Law Development. In 2018, the Property and Casualty Insurance (C) Committee appointed the Lender-Placed Insurance Model Act (C) Working Group to only focus on drafting a new model related to lender-placed homeowners’ insurance.

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

The Lender-Placed Insurance Model Act (C) Working Group reviewed sections of the Real Property Lender-Place Insurance Model Act (Model) on various conference calls and asked for comments on an ongoing basis throughout 2017 and 2018. A draft of the Model was exposed in March 2018, and it was discussed on Sept. 18, 2018. The final draft of the Model was exposed on Oct. 19, 2020, through Nov. 3, 2020.

Numerous written comments were submitted to the Working Group, including from the Center for Economic Justice (CEJ); the National Consumer Law Center (NCLC), a joint industry group made up of the American Bankers Association (ABA), the Consumer Credit Industry Association (CCIA), the Council of Insurance Agents & Brokers, the National Association of Mutual Insurance Companies (NAMIC), and the American Property Casualty Insurance Association (APCIA); as well as numerous states.

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

Once the focus of the Model was limited to real property in 2018, the Lender-Placed Insurance Model Act (C) Working Group exposed the draft of a new model law for real property LPI in March 2018 for a 45-day public comment period ending April 30, 2018. On Sept. 18, 2018, the Working Group reviewed comments received, as well as a new draft of the Model reflecting those comments. The Working Group exposed the new draft through Oct. 31, 2018.

The Working Group met Oct. 19, 2020, to hear from commenters on the most recent version of the proposed Model and to expose the Model for a 15-day public comment period ending Nov. 3, 2020.

On Nov. 13, 2020, the Working Group met to hear from commenters and review new edits to the Model made by Rhode Island. The Working Group agreed to several changes to the Model and unanimously adopted the Model during this conference call.
6. **A Discussion of the Significant Issues (items of some controversy raised during the due process and the group’s response)**

Scope of the Model: Early on, consideration was given to revising Model #375 so that it would include both personal property and real property. The Lender-Placed Insurance Model Act (C) Working Group decided to create a new model focused on real property, and a model law request was adopted by the Property and Casualty Insurance (C) Committee on July 18, 2017. In its 2018 charges, the Working Group was charged with only creating a new model focused on real property.

Tracking Expenses and Review of Rates: Some commenters wanted a prohibition of tracking expenses because they said servicers are paid for tracking, and the practice of allowing insurers to provide free tracking and recoup the cost from LPI premiums is unfair. Working Group members argued that states retain the authority to review expenses in rate filings and judge whether expenses are appropriate to pass to consumers. The Working Group agreed to revise Section 9B to read: “The Commissioner shall review the rates to determine whether the rates are excessive, inadequate or unfairly discriminatory. This analysis shall include a determination as to whether expenses included by the insurer in the rate are appropriate.”

Loss Ratios: Some commenters argued for a lower loss ratio threshold. The Working Group agreed to a drafting note following Section 9G that reads: “The 35% trigger for re-filing rates is not intended to be nor should be interpreted as a loss ratio standard for determining whether rates are excessive or inadequate. The loss ratio standard in this section is solely directed to prompt a re-filing of rates by the insurer.”

Single and Dual-Interest: Some commenters argued that only dual-interest LPI be permitted because the borrower is named as an additional insured with dual-interest and has some rights to file a claim under the policy. The Working Group found most policies to be dual-interest, and it decided not to include a prohibition of single-interest LPI within the Model.

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

None.
Casualty Actuarial and Statistical (C) Task Force

Regulatory Review of Predictive Models

White Paper

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I. INTRODUCTION

Insurers’ use of predictive analytics along with big data has significant potential benefits to both consumers and insurers. Predictive analytics can reveal insights into the relationship between consumer behavior and the cost of insurance, lower the cost of insurance for many, and provide incentives for consumers to better control and mitigate loss. However, predictive analytic techniques are evolving rapidly and leaving many state insurance regulators, who must review these techniques, without the necessary tools to effectively review insurers’ use of predictive models in insurance applications.

When a rate plan is truly innovative, the insurer must anticipate or imagine the reviewers’ interests because reviewers will respond with unanticipated questions and have unique educational needs. Insurers can learn from the questions, teach the reviewers, and so forth. When that back-and-forth learning is memorialized and retained, filing requirements and insurer presentations can be routinely organized to meet or exceed reviewers’ needs and expectations. Hopefully, this white paper helps bring more consistency to the art of reviewing predictive models within a rate filing and make the review process more efficient.

The Casualty Actuarial and Statistical (C) Task Force has been charged with identifying best practices to serve as a guide to state insurance departments in their review of the predictive models underlying rating plans. There were two charges given to Task Force by the Property and Casualty Insurance (C) Committee at the request of the Big Data (EX) Working Group:

- Draft and propose changes to the Product Filing Review Handbook to include best practices for review of predictive models and analytics filed by insurers to justify rates.

- Draft and propose state guidance (e.g., information, data) for rate filings based on complex predictive models.

This white paper will identify best practices for the review of predictive models and analytics filed by insurers with regulators to justify rates and will provide state guidance for the review of rate filings based on predictive models. Upon adoption of this white paper by the Executive (EX) Committee and Plenary, the Task Force will make a recommendation to incorporate these best practices into the Product Filing Review Handbook and will forward that recommendation to the Speed to Market (EX) Working Group.

As discussed further in the body of the white paper, this document is intended as guidance for state insurance regulators as they review predictive models. Nothing in this document is intended to, or could, change the applicable legal and regulatory standards for approval of rating plans. This guidance is intended only to assist state insurance regulators as they review models to determine whether modeled rates are compliant with existing state laws and/or regulations. To the extent these best practices are incorporated into the Product Filing Review Handbook, the handbook provides that it is intended to “add uniformity and consistency of regulatory processes, while maintaining the benefits of the application of unique laws and regulations that address the state-specific needs of the nation’s insurance consumers.”

II. WHAT IS A “BEST PRACTICE”?  

A best practice is a form of program evaluation in public policy. At its most basic level, a practice is a “tangible and visible behavior… [based on] an idea about how the actions…will solve a problem or achieve a goal.” 2 Best practices are used to maintain quality as an alternative to mandatory legislated standards and can be based on self-assessment or benchmarking. 3 Therefore, a best practice represents an effective method of problem solving. The “problem” regulators want to solve is probably better posed as seeking an answer to this question: How can regulators determine whether predictive models, as used in rate filings, are compliant with state laws and/or regulations?

Key Regulatory Principles

In this white paper, best practices are based on the following principles that promote a comprehensive and coordinated review of predictive models across the states:

1. State insurance regulators will maintain their current rate regulatory authority and autonomy.

1 In this white paper, references to “model” or “predictive model” are the same as “complex predictive model” unless qualified.


2. State insurance regulators will be able to share information to aid companies in getting insurance products to market more quickly across the states.4

3. State insurance regulators will share expertise and discuss technical issues regarding predictive models to make the review process in any state more effective and efficient.

4. State insurance regulators will maintain confidentiality, in accordance with state law, regarding predictive models.

Best practices are presented to state insurance regulators for the review of predictive models and to insurance companies as a consideration in filing rating plans that incorporate predictive models. As a byproduct of identifying these best practices, general and specific information elements were identified that could be useful to a regulator when reviewing a rating plan that is wholly or in part based on a generalized linear model (GLM). For the states that are interested, the information elements are identified in Appendix B, including comments on what might be important about that information and, where appropriate, providing insight as to when the information might identify an issue the regulator needs to be aware of or explore further. Lastly, provided in this white paper are glossary terms (see Appendix C) and references (contained in the footnotes) that can expand a state insurance regulator’s knowledge of predictive models (GLMs specifically).

III. SOME ISSUES IN REVIEWING TODAY’S PREDICTIVE MODELS

The term “predictive model” refers to a set of models that use statistics to predict outcomes.5 When applied to insurance, the model is chosen to estimate the probability or expected value of an outcome given a set amount of input data; for example, models can predict the frequency of loss, the severity of loss, or the pure premium. The GLM6 is a commonly used predictive model in insurance applications, particularly in building an insurance product’s rating plan.

Depending on definitional boundaries, predictive modeling can sometimes overlap with the field of machine learning. In this modeling space, predictive modeling is often referred to as predictive analytics.

Before GLMs became vogue, rating plans were built using univariate methods. Univariate methods were considered intuitive and easy to demonstrate the relationship to costs (loss and/or expense). Today, many insurers consider univariate methods too simplistic because they do not take into account the interaction (or dependencies) of the selected input variables.

Today, the majority of predictive models used in personal automobile and home insurance rating plans are GLMs.7 According to many in the insurance industry, GLMs introduce significant improvements over univariate-based rating plans by automatically adjusting for correlations among input variables. However, it is not always easy to understand the complex predictive model output’s relationship to cost. This creates a problem for the state insurance regulator when model results are difficult to explain to someone (e.g., a consumer) who has little to no expertise in modeling techniques.

Generalized Linear Models

A GLM consists of three elements:8

- A target variable, Y, which is a random variable that is independent and is assumed to follow a probability distribution from the exponential family, defined by a selected variance function and dispersion parameter.
- A linear predictor, $\eta = X\beta$.
- A link function g, such that $E(Y) = \mu = g^{-1}(\eta)$.

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4 The states can share information if they can maintain confidentiality and legally share such information. Information about a classification plan documented in one state could be shared with another state.

5 A more thorough exploration of different predictive models will be found in many books on statistics, including:

6 The GLM is a flexible family of models that are unified under a single method. Types of GLMs include logistic regression, Poisson regression, gamma regression, and multinomial regression.


8 Information on model elements can be found in most books on statistics.
As can be seen in the description of the three GLM components above, it may take more than a casual introduction to statistics to comprehend the construction of a GLM. As stated earlier, a downside to GLMs is that it is more challenging to interpret a GLM’s output than that of a univariate model.

To further complicate the regulatory review of models in the future, modeling methods are evolving rapidly and are not limited just to GLMs. As computing power grows exponentially, it is opening the modeling world to more sophisticated forms of data acquisition and data analysis. Insurance actuaries and data scientists seek increased predictiveness by using even more complex predictive modeling methods. Examples of these methods include predictive models utilizing random forests, decision trees, neural networks, or combinations of available modeling methods (often referred to as “ensembles”). These evolving techniques will make a state insurance regulator’s understanding and oversight of filed rating plans that incorporate predictive models even more challenging.

In addition to the growing complexity of predictive models, many state insurance departments do not have in-house actuarial support or have limited resources to contract out for support when reviewing rate filings that include the use of predictive models. The Big Data (EX) Working Group identified the need to provide the states with guidance and assistance when reviewing predictive models underlying filed rating plans.9 The Working Group circulated a proposal addressing aid to state insurance regulators in the review of predictive models as used in personal automobile and home insurance rate filings. This proposal was circulated to all Working Group members and interested parties on Dec. 19, 2017, for a public comment period ending Jan. 12, 2018.10 The Working Group’s effort resulted in new charges for the Casualty Actuarial and Statistical (C) Task Force (see Section I—Introduction) to identify best practices that provide guidance to the states in their review of predictive models.

Credibility of GLM Output

If the underlying data is not credible, then no model will improve that credibility, and segmentation methods could make credibility worse. GLM software provides point estimates and allows the modeler to consider standard errors and confidence intervals. GLMs effectively assume that the underlying datasets are 100% credible, no matter their size. If some segments have little data, the resulting uncertainty would not be reflected in the GLM parameter estimates themselves (although it might be reflected in the standard errors, confidence intervals, etc.). Even though the process of selecting relativities often includes adjusting the raw GLM output, the resultant selections are typically not credibility-weighted with any complement of credibility.11,12 And, selected relativities based on GLM model output may differ from GLM point estimates. Lack of credibility for particular estimates could be discerned if standard errors are large relative to the point estimates and/or if the confidence intervals are broad.

Because of this presumption in credibility, which may or may not be valid in practice, the modeler—and the state insurance regulator reviewing the model—would need to engage in thoughtful consideration when incorporating GLM output into a rating plan to ensure that model predictiveness is not compromised by any lack of actual credibility. Another consideration is the availability of data, both internal and external, that may result in the selection of predictor variables that have spurious correlation with the target variable. Therefore, to mitigate the risk that model credibility or predictiveness is lacking, a complete filing for a rating plan that incorporates GLM output should include validation evidence for the rating plan, not just the statistical model.

IV. DO REGULATORS NEED BEST PRACTICES TO REVIEW PREDICTIVE MODELS?

It might be better to revise the question of “Do regulators need best practices to review predictive models?” to “Are best practices in the review of predictive models of value to regulators and insurance companies?” The answer is “yes” to both questions.

Regulatory best practices need to be developed that do not unfairly or inordinately create barriers for insurers, and ultimately consumers, while providing a baseline of analysis for state insurance regulators to review the referenced filings. Best practices will aid regulatory reviewers by raising their level of model understanding. Also, with regard to scorecard
models and the model algorithm, there is often not sufficient support for relative weight, parameter values, or scores of each variable. Best practices can potentially aid in addressing this problem.

Best practices are not intended to create standards for filings that include predictive models. Rather, best practices will assist the states in identifying the model elements they should be looking for in a filing that will aid the regulator in understanding why the company believes that the filed predictive model improves the company’s rating plan and, therefore, makes that rating plan fairer to all consumers in the marketplace. To make this work, state insurance regulators and the industry need to recognize that:

- Best practices provide guidance to state insurance regulators in their essential and authoritative role over the rating plans in their respective state.
- Every state may have a need to review predictive models, whether that occurs during the approval process of a rating plan or during a market conduct exam. Best practices help the state insurance regulator identify elements of a model that may influence the regulatory review as to whether modeled rates are appropriately justified, compliant with state laws and/or regulations, and whether to act on that information.
- Best practices provide a framework for the states to share knowledge and resources to facilitate the technical review of predictive models.
- Best practices can lead to improved quality in predictive model reviews across the states, aiding speed to market and competitiveness of the state’s insurance marketplace.
- Best practices aid training of new state insurance regulators and/or regulators new to reviewing predictive models. This is especially useful for those regulators who do not actively participate in NAIC discussions related to the subject of predictive models.
- Each state insurance regulator adopting best practices will be better able to identify the resources needed to assist their state in the review of predictive models.

V. SCOPE

The best practices identified in this white paper were derived from a ground-up study and analysis of how GLMs are used in personal automobile and home insurance rating plans. These three components (GLM, PPA, and HO) were selected as the basis to develop best practices for the regulatory review of predictive models because many state insurance regulators are familiar with, and have expertise in, such filings. In addition, the legal and regulatory constraints (including state variations) are likely to be more evolved, and challenging, for personal automobile and home insurance. It is through a review of these personal lines and the knowledge needed to review GLMs used in their rate filings that will provide meaningful best practices for state insurance regulators. The identified best practices should be readily transferrable when the review involves other predictive models applied to other lines of business or for an insurance purpose other than rating.

VI. CONFIDENTIALITY

Each state determines the confidentiality of a rate filing and the supplemental material to the filing, when filing information might become public, the procedure to request that filing information be held confidentially, and the procedure by which a public records request is made. Regulatory reviewers are required to protect confidential information in accordance with applicable state law. State insurance regulators should be aware of their state laws on confidentiality when requesting data from insurers that may be proprietary or a trade secret. However, insurers should be aware that a rate filing might become part of the public record. It is incumbent on an insurer to be familiar with each state’s laws regarding the confidentiality of information submitted with its rate filing.

State authority, regulations and/or rules governing confidentiality always apply when a state insurance regulator reviews a model used in rating. When the NAIC or a third party enters the review process, the confidential, proprietary, and trade secret protections of the state on behalf of which a review is being performed will continue to apply.

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13 See Appendix B.
VII. BEST PRACTICES FOR THE REGULATORY REVIEW OF PREDICTIVE MODELS

Best practices will help the state insurance regulator understand if a predictive model is cost-based, if the predictive model is compliant with state law, and how the model improves a company’s rating plan. Best practices can also improve the consistency among the regulatory review processes across the states and improve the efficiency of each regulator’s review, thereby helping companies get their products to market faster. With this in mind, the regulator’s review of predictive models should:

1. Ensure that the selected rating factors, based on the model or other analysis, produce rates that are not excessive, inadequate, or unfairly discriminatory.
   a. Review the overall rate level impact of the proposed revisions to rate level indications provided by the filer.
   b. Determine whether individual input characteristics to a predictive model and their resulting rating factors are related to the expected loss or expense differences in risk.
   c. Review the premium disruption for individual policyholders and how the disruptions can be explained to individual consumers.
   d. Review the individual input characteristics to, and output factors from, the predictive model (and its sub-models), as well as associated selected relativities, to ensure they are compatible with practices allowed in the state and do not reflect prohibited characteristics.

2. Obtain a clear understanding of the data used to build and validate the model, and thoroughly review all aspects of the model, including assumptions, adjustments, variables, sub-models used as input, and resulting output.
   a. Obtain a clear understanding of how the selected predictive model was built.
   b. Determine whether the data used as input to the predictive model is accurate, including a clear understanding how missing values, erroneous values, and outliers are handled.
   c. Determine whether any adjustments to the raw data are handled appropriately, including, but not limited to, trending, development, capping, and removal of catastrophes.
   d. Obtain a clear understanding of how often each risk characteristic used as input to the model is updated and whether the model is periodically refreshed, to help determine whether the model output reflects changes to non-static risk characteristics.

3. Evaluate how the model interacts with and improves the rating plan.
   a. Obtain a clear understanding of the characteristics that are input to the predictive model (and its sub-models).
   b. Obtain a clear understanding of how the insurer integrates the model into the rating plan and how it improves the rating plan.
   c. Obtain a clear understanding of how the model output interacts with non-modeled characteristics/variables used to calculate a risk’s premium.

4. Enable competition and innovation to promote the growth, financial stability, and efficiency of the insurance marketplace.
   a. Enable innovation in the pricing of insurance through the acceptance of predictive models, provided such models are in compliance with state laws and/or regulations, particularly prohibitions on unfair discrimination.
   b. Protect the confidentiality of filed predictive models and supporting information in accordance with state laws and/or regulations.
   c. Review predictive models in a timely manner to enable reasonable speed to market.
VIII. PROPOSED CHANGES TO THE PRODUCT FILING REVIEW HANDBOOK

The Task Force was charged to propose modifications to the 2016 Product Filing Review Handbook to reflect best practices for the regulatory review of GLM predictive analytics. The following are the titled sections in Chapter Three—The Basics of Property and Casualty Rate Regulation.

No changes are proposed to the following sections of Chapter Three: Introduction; Rating Laws; Rate Standards; Rate Justification and Supporting Data; Number of Years of Historical Data; Segregation of Data; Data Adjustments; Premium Adjustments; Losses and LAE (perhaps just DCC) Adjustments; Catastrophe or Large Loss Provisions; Loss Adjustment Expenses; Data Quality; Rate Justification: Overall Rate Level; Contingency Provision; Credibility; Calculation of Overall Rate Level Need: Methods (Pure Premium and Loss Ratio Methods); Rate Justification: Rating Factors; Calculation of Deductible Rating Factors; Calculation of Increased Limit Factors; and Credibility for Rating Factors.

The following are the proposed changes to the remainder of Chapter Three:

Interaction between Rating Variables (Multivariate Analysis)

If each rating variable is evaluated separately, statistically significant interactions between rating variables may not be identified and, thus, may not be included in the rating plan. Care should be taken to have a multivariate analysis when practical. In some instances, a multivariate analysis is not possible. But, with computing power growing exponentially, insurers believe they have found many ways to improve their operations and competitiveness through use of complex predictive models in all areas of their insurance business.

Approval of Classification Systems

With rate changes, companies sometimes propose revisions to their classification system. Because the changes to classification plans can be significant and have large impacts on the consumers’ rates, regulators should focus on these changes.

Some items of proposed classification can sometimes be deemed to be contrary to state laws and/or regulations, such as the use of education or occupation. You should be aware of your state’s laws and regulations regarding which rating factors are allowed, and you should require definitions of all data elements that can affect the charged premium. Finding rating or underwriting characteristics that may violate state laws and/or regulations is becoming more difficult for regulators with the increasing and innovative ways insurers use predictive models.

Rating Tiers – (No change is proposed.)

Rate Justification: New Products – (No change is proposed.)

Predictive Modeling

The ability of computers to process massive amounts of data (referred to as “big data”) has led to the expansion of the use of predictive modeling in insurance ratemaking. Predictive models have enabled insurers to build rating, marketing, underwriting, and claim models with significant predictive ability.

Data quality within, and communication about, models are of key importance with predictive modeling. Depending on definitional boundaries, predictive modeling can sometimes overlap with the field of machine-learning. In the modeling space, predictive modeling is often referred to as “predictive analytics.”

Insurers’ use of predictive analytics along with big data has significant potential benefits to consumers and insurers. Predictive analytics can reveal insights into the relationship between consumer behavior and the cost of insurance, lower the cost of insurance for many, and provide incentives for consumers to better control and mitigate loss. However, predictive analytic techniques are evolving rapidly and leaving many state insurance regulators without the necessary tools to effectively review
insurers’ use of predictive models in insurance applications. To aid the regulator in the review of predictive models, best practices have been developed.

The term “predictive model” refers to a set of models that use statistics to predict outcomes. When applied to insurance, the model is chosen to estimate the probability or expected value of an outcome given a set amount of input data; for example, models can predict the frequency of loss, the severity of loss, or the pure premium.

To further complicate regulatory review of models in the future, modeling technology and methods are evolving rapidly. Generalized linear models (GLMs) are relatively transparent and their output and consequences are much clearer than many other complex models. But as computing power grows exponentially, it is opening the modeling world to more sophisticated forms of data acquisition and data analysis. Insurance actuaries and data scientists seek increased predictiveness by using even more complex predictive modeling methods. Examples of these methods are predictive models utilizing logistic regression, K-nearest neighbor classification, random forests, decision trees, neural networks, or combinations of available modeling methods (often referred to as “ensembles”). These evolving techniques will make the regulators’ understanding and oversight of filed rating plans even more challenging.

**Generalized Linear Models**

The GLM is a commonly used predictive model in insurance applications, particularly in building an insurance product’s rating plan. Because of this and the fact most property/casualty regulators are most concerned about personal lines, the NAIC has developed an appendix in its white paper for guidance in reviewing GLMs for personal automobile and home insurance.

**What is a “Best Practice”?**

A best practice is a form of program evaluation in public policy. At its most basic level, a practice is a “tangible and visible behavior… [based on] an idea about how the actions… will solve a problem or achieve a goal.” Best practices can maintain quality as an alternative to mandatory legislated standards and can be based on self-assessment or benchmarking. Therefore, a best practice represents an effective method of problem solving. The “problem” regulators want to solve is probably better posed as seeking an answer to this question: How can regulators determine whether predictive models, as used in rate filings, are compliant with state laws and/or regulations? However, best practices are not intended to create standards for filings that include predictive models.

Best practices are based on the following principles that promote a comprehensive and coordinated review of predictive models across the states:

- State insurance regulators will maintain their current rate regulatory authority and autonomy.
- State insurance regulators will be able to share information to aid companies in getting insurance products to market more quickly across the states.
- State insurance regulators will share expertise and discuss technical issues regarding predictive models to make the review process in any state more effective and efficient.
- State insurance regulators will maintain confidentiality, in accordance with state laws and/or regulations, regarding predictive models.

**Best Practices for the Regulatory Review of Predictive Models**

Best practices will help the regulator understand if a predictive model is cost-based, if the predictive model is compliant with state laws and/or regulations, and how the model improves the company’s rating plan. Best practices can also improve the consistency among the regulatory review processes across the states and improve the efficiency of each regulator’s review, thereby assisting companies in getting their products to market faster. With this in mind, the regulator’s review of predictive models should:

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14 Refer to Appendix B in the NAIC white paper, *Regulatory Review of Predictive Models*.


1. Ensure that the selected rating factors, based on the model or other analysis, produce rates that are not excessive, inadequate, or unfairly discriminatory.
   a. Review the overall rate level impact of the proposed revisions to rate level indications provided by the filer.
   b. Determine whether individual input characteristics to a predictive model and their resulting rating factors are related to the expected loss or expense differences in risk.
   c. Review the premium disruption for individual policyholders and how the disruptions can be explained to individual consumers.
   d. Review the individual input characteristics to, and output factors from, the predictive model (and its sub-models), as well as associated selected relativities, to ensure they are compatible with practices allowed in the state and do not reflect prohibited characteristics.

2. Obtain a clear understanding of the data used to build and validate the model, and thoroughly review all aspects of the model, including assumptions, adjustments, variables, sub-models used as input, and resulting output.
   a. Obtain a clear understanding of how the selected predictive model was built.
   b. Determine whether the data used as input to the predictive model is accurate, including a clear understanding how missing values, erroneous values, and outliers are handled.
   c. Determine whether any adjustments to the raw data are handled appropriately, including, but not limited to, trending, development, capping, and removal of catastrophes.
   d. Obtain a clear understanding of how often each risk characteristic, used as input to the model, is updated and whether the model is periodically refreshed, so model output reflects changes to non-static risk characteristics.

3. Evaluate how the model interacts with and improves the rating plan.
   a. Obtain a clear understanding of the characteristics that are input to a predictive model (and its sub-models).
   b. Obtain a clear understanding how the insurer integrates the model into the rating plan and how it improves the rating plan.
   c. Obtain a clear understanding of how model output interacts with non-modeled characteristics/variables used to calculate a risk’s premium.

4. Enable competition and innovation to promote the growth, financial stability, and efficiency of the insurance marketplace.
   a. Enable innovation in the pricing of insurance through acceptance of predictive models, provided such models are in compliance with state laws and/or regulations, particularly prohibitions on unfair discrimination.
   b. Protect the confidentiality of filed predictive models and supporting information in accordance with state laws and/or regulations.
   c. Review predictive models in a timely manner to enable reasonable speed to market.

Confidentiality

Each state determines the confidentiality of a rate filing and the supplemental material to the filing, when filing information might become public, the procedure to request that filing information be held confidentially, and the procedure by which a public records request is made. Regulatory reviewers are required to protect confidential information in accordance with applicable state laws and/or regulations. State insurance Regulators should be aware of their state laws and/or regulations on confidentiality when requesting data from insurers that may be proprietary or trade secret. However, insurers should be aware that a rate filing might become part of the public record. It is incumbent on an insurer to be familiar with each state’s laws and/or regulations regarding the confidentiality of information submitted with their rate filing.

State authority, regulations and rules governing confidentiality always apply when a regulator reviews a model used in rating. When the NAIC or a third party enters into the review process, the confidential, proprietary, and trade secret protections of the state on behalf of which a review is being performed will continue to apply.
Advisory Organizations – (No change is proposed.)

Workers’ Compensation Special Rules – (No change is proposed.)

Premium Selection Decisions – (No change is proposed.)

Installment Plans – (No change is proposed.)

Policy Fees – (No change is proposed.)

Potential Questions to Ask Oneself as a Regulator – (No change is proposed.)

Questions to Ask a Company

If you remain unsatisfied that the company has satisfactorily justified the rate change, then consider asking additional questions of the company. Questions should be asked of the company when it has not satisfied statutory or regulatory requirements in the state or when any current justification is inadequate and could have an impact on the rate change approval or the amount of the approval.

If there are additional items of concern, the company can be notified so it can make appropriate modifications in future filings.

The NAIC white paper, Regulatory Review of Predictive Models, documents questions that a state insurance regulator may want to ask when reviewing a model. These questions are listed as “information elements” in Appendix B of the white paper. Note: Although Appendix B focuses on GLMs for personal automobile and home insurance, many of the “information elements” and concepts they represent may be transferable to other types of models, other lines of business, and other applications beyond rating.

Additional Ratemaking Information

The Casualty Actuarial Society (CAS) and the Society of Actuaries (SOA) have extensive examination syllabi that contain a significant amount of ratemaking information, on both the basic topics covered in this chapter and on advanced ratemaking topics. The CAS and SOA websites (https://www.casact.org and https://www.soa.org, respectively) contain links to many of the papers included in the syllabi. Recommended reading is the Foundations of Casualty Actuarial Science, which contains chapters on ratemaking, risk classification, and individual risk rating.

Other Reading

Additional background reading is recommended:

  - Chapter 1: Introduction
  - Chapter 3: Ratemaking
  - Chapter 6: Risk Classification
  - Chapter 9: Investment Issues in Property-Liability Insurance
  - Chapter 10: Only the section on Regulating an Insurance Company, pp. 777–787
- CAS: Statements of Principles, especially regarding property/casualty ratemaking.
- CAS: “Basic Ratemaking.”
- Association of Insurance Compliance Professionals: “Ratemaking: What the State Filer Needs to Know.”
- Review of filings and approval of insurance company rates.
Summary

Rate regulation for property/casualty lines of business requires significant knowledge of state rating laws, rating standards, actuarial science, statistical modeling, and many data concepts.

- Rating laws vary by state, but the rating laws are usually grouped into prior approval, file and use or use and file (competitive), no file (open competition), and flex rating.
- Rate standards typically included in the state rating laws require that “rates shall not be inadequate, excessive, or unfairly discriminatory.”
- A company will likely determine its indicated rate change by starting with historical years of underwriting data (earned premiums, incurred loss and loss adjustment expenses, and general expenses) and adjusting that data to reflect the anticipated ultimate level of costs for the future time period covered by the policies. Numerous adjustments are made to the data. Common premium adjustments are on-level premium, audit, and trend. Common loss adjustments are trend, loss development, catastrophe/large loss provisions, and an adjusting and other (A&O) loss adjustment expense provision. A profit/contingency provision is also calculated to determine the indicated rate change.
- Once an overall rate level is determined, the rate change gets allocated to the classifications and other rating factors.
- Individual risk rating allows manual rates to be modified by an individual policyholder’s own experience.
- Advisory organizations provide the underlying loss costs for companies to be able to add their own expenses and profit provisions (with loss cost multipliers) to calculate their insurance rates.
- The CAS’ Statement of Principles Regarding Property and Casualty Insurance Ratemaking provides guidance and guidelines for the numerous actuarial decisions and standards employed during the development of rates.
- NAIC model laws and regulations include special provisions for workers’ compensation business, penalties for not complying with state laws and/or regulations, and competitive market analysis to determine whether rates should be subject to prior-approval provisions.
- Best practices for reviewing predictive models are provided in the NAIC white paper, Regulatory Review of Predictive Models. The best practices and many of the information elements and underlying concepts may be transferrable to other types of models, other lines of insurance, and applications beyond rating.

While this chapter provides an overview of the rate determination/actuarial process and regulatory review, state statutory or administrative rule may require the examiner to employ different standards or guidelines than the ones described.

No additional changes are proposed to the Product Filing Review Handbook.

IX. PROPOSED STATE GUIDANCE

This white paper acknowledges that different states will apply the guidance within this white paper differently, based on variations in the legal environment pertaining to insurance regulation in those states, as well as the extent of available resources, including staff members with actuarial and/or statistical expertise, the workloads of those staff members, and the time that can be reasonably allocated to predictive-model reviews. The states with prior-approval authority over personal lines rate filings often already require answers in connection with many of the information elements expressed in this white paper. However, the states—including those with and without prior-approval authority—may also use the guidance in this white paper to choose which model elements to focus on in their reviews and/or to train new reviewers, as well as to gain an enhanced understanding of how predictive models are developed, supported, and deployed in their markets. Ultimately, the insurance regulators within each state will decide how best to tailor the guidance within this white paper to achieve the most effective and successful implementation, subject to the framework of statutes, regulations, precedents, and/or processes that comprise the insurance regulatory framework in that state.
X. OTHER CONSIDERATIONS

During the development of state guidance for the review of predictive models used in rate filings, important topics that may impact the review arose that were not within the scope of this white paper. The topics are listed below without elaboration and not in any order of importance. Note: This is not an exhaustive list. These topics may need to be addressed during the regulator’s review of a predictive model. It may be that one or more of the following topics will be addressed by an NAIC committee in the future:

- Provide guidance for state insurance regulators to identify when a rating variable or rating plan becomes too granular.
- Provide guidance for state insurance regulators on the importance of causality versus correlation when evaluating a rating variable’s relationship to risk, in general and in relation to Actuarial Standard of Practice (ASOP) No. 12, Risk Classification (for All Practice Areas).
- Provide guidance for state insurance regulators on the value and/or concerns of data mining, including how data mining may assist in the model building process, how data dredging may conflict with standard scientific principles, how data dredging may increase “false positives” during the model building process, and how data dredging may result in less accurate models and/or models that are unfairly discriminatory.
- Provide guidance and/or tools for state insurance regulators to determine how a policy premium is calculated and to identify the most important risk characteristics that underlie the calculated premium.
- Provide guidance for state insurance regulators when reviewing consumer-generated data in insurance transactions, including disclosure to the consumer, ownership of data, and verification of data procedures.
- Provide guidance, research tools, and techniques for state insurance regulators to monitor consumer market outcomes resulting from insurers’ use of data analytics underlying rating plans.
- Provide guidance for state insurance regulators to expand the best practices and information elements contained in this white paper to non-GLM models and insurance applications other than for personal automobile and home insurance rating plans.
- Provide guidance for state insurance regulators to determine whether individual input characteristics to a model or a sub-model, as well as associated relativities, are not unfairly discriminatory or a “proxy for a protected class.”
- Provide guidance for state insurance regulators to identify and minimize unfair discrimination manifested as “disparate impact.”
- Provide guidance for state insurance regulators that seek a causal or rational explanation why a rating variable is correlated to expected loss or expense, and why that correlation is consistent with the expected direction of the relationship.
APPENDIX A – BEST PRACTICES DEVELOPMENT

The development of best practices is a method for reviewing public policy processes that have been effective in addressing particular issues and could be applied to a current problem. This process relies on the assumptions that top performance is a result of good practices and these practices may be adapted and emulated by others to improve results.17

The term “best practice” can be a misleading one due to the slippery nature of the word “best.” When proceeding with policy research of this kind, it may be more helpful to frame the project as a way of identifying practices and/or processes that have worked exceptionally well and the underlying reasons for their success. This allows for a mix-and-match approach for making recommendations that might encompass pieces of many good practices.18

Researchers have found that successful best-practice analysis projects share five common phases:

1. **Define Scope**

   The focus of an effective analysis is narrow, precise, and clearly articulated to stakeholders. A project with a broader focus becomes unwieldy and impractical. Furthermore, Bardach urges the importance of realistic expectations in order to avoid improperly attributing results to a best practice without taking into account internal validity problems.

2. **Identify Top Performers**

   Identify outstanding performers in this area to partner with and learn from. In this phase, it is key to recall that a best practice is a tangible behavior or process designed to solve a problem or achieve a goal (i.e., reviewing predictive models contributes to insurance rates that are not unfairly discriminatory). Therefore, top performers are those who are particularly effective at solving a specific problem or regularly achieve desired results in the area of focus.

3. **Analyze Best Practices**

   Once successful practices are identified, analysts will begin to observe, gather information, and identify the distinctive elements that contribute to their superior performance. Bardach suggests it is important at this stage to distill the successful elements of the process down to their most essential idea. This allows for flexibility once the practice is adapted for a new organization or location.

4. **Adapt**

   Analyze and adapt the core elements of the practice for application in a new environment. This may require changing some aspects to account for organizational or environmental differences while retaining the foundational concept or idea. This is also the time to identify potential vulnerabilities of the new practice and build in safeguards to minimize risk.

5. **Implement and Evaluate**

   The final step is to implement the new process and carefully monitor the results. It may be necessary to make adjustments, so it is likely prudent to allow time and resources for this. Once implementation is complete, continued evaluation is important to help ensure the practice remains effective.

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APPENDIX B – INFORMATION ELEMENTS AND GUIDANCE FOR A REGULATOR TO MEET BEST PRACTICES’ OBJECTIVES (WHEN REVIEWING GLMS)

This appendix identifies the information a state insurance regulator may need to review a predictive model used by an insurer to support a personal automobile or home insurance rating plan. The list is lengthy but not exhaustive. It is not intended to limit the authority of a regulator to request additional information in support of the model or filed rating plan. Nor is every item on the list intended to be a requirement for every filing. However, the items listed should help guide a regulator to sufficient information that helps determine if the rating plan meets state-specific filing and legal requirements.

Documentation of the design and operational details of the model will help ensure the business continuity and transparency of the models used. Documentation should be sufficiently detailed and complete to enable a qualified third party to form a sound judgment on the suitability of the model for the intended purpose. The theory, assumptions, methodologies, software, and empirical bases should be explained, as well as the data used in developing and implementing the model. Relevant testing and ongoing performance testing need to be documented. Key model limitations and overrides need to be pointed out so that stakeholders understand the circumstances under which the model does not work effectively. End-user documentation should be provided and key reports using the model results described. Major changes to the model need to be documented and shared with regulators in a timely and appropriate manner. Information technology (IT) controls should be in place, such as a record of versions, change control, and access to the model.

Many information elements listed below are probably confidential, proprietary, or trade secret and should be treated as such, in accordance with state laws and/or regulations. Regulators should be aware of their state laws and/or regulations on confidentiality when requesting data from insurers that may be proprietary or trade secret. For example, some proprietary models may have contractual terms (with the insurer) that prevent disclosure to the public. Without clear necessity, exposing this data to additional dissemination may compromise the model’s protection.

Although the list of information is long, the insurer should already have internal documentation on the model for more than half of the information listed. The remaining items on the list require either minimal analysis (approximately 25%) or deeper analysis to generate for a regulator (approximately 25%).

The “Level of Importance to the Regulator’s Review” is a ranking of information a regulator may need to review which is based on the following level criteria:

Level 1 – This information is necessary to begin the review of a predictive model. These data elements pertain to basic information about the type and structure of the model, the data and variables used, the assumptions made, and the goodness of fit. Ideally, this information would be included in the filing documentation with the initial submission of a filing made based on a predictive model.

Level 2 – This information is necessary to continue the review of all but the most basic models, such as those based only on the filer’s internal data and only including variables that are in the filed rating plan. These data elements provide more detailed information about the model and address questions arising from review of the information in Level 1. Insurers concerned with speed to market may also want to include this information in the filing documentation.

Level 3 – This information is necessary to continue the review of a model where concerns have been raised and not resolved based on review of the information in Level 1 and Level 2. These data elements address even more detailed aspects of the model. This information does not necessarily need to be included with the initial submission, unless specifically requested by a particular state, as it is typically requested only if the reviewer has concerns that the model may not comply with state laws and/or regulations.

Level 4 – This information is necessary to continue the review of a model where concerns have been raised and not resolved based on the information in Level 1, Level 2, and Level 3. This most granular level of detail is addressing the basic building blocks of the model and does not necessarily need to be included by the filer with the initial submission, unless specifically requested by a particular state. It is typically requested only if the reviewer has serious concerns that the model may produce rates or rating factors that are excessive, inadequate, and/or unfairly discriminatory.


20 There are some models that are made public by the vendor and would not result in a hindrance of the model’s protection.
Lastly, although the best practices presented in this white paper will readily be transferrable to review of other predictive models, the information elements presented here might be useful only with deeper adaptations when starting to review different types of predictive models. If the model is not a GLM, some listed items might not apply; e.g., not all predictive models generate p-values or F tests. Depending on the model type, other considerations might be important but are not listed here. When information elements presented in this appendix are applied to lines of business other than personal automobile and home insurance or other type of models, unique considerations may arise. In particular, data volume and credibility may be lower for other lines of business. Regulators should be aware of the context in which a predictive model is deployed, the uses to which the model is proposed to be put, and the potential consequences the model may have on the insurer, its customers, and its competitors. This white paper does not delve into these possible considerations, but regulators should be prepared to address them as they arise.
A. SELECTING MODEL INPUT

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<tr>
<td>1. Available Data Sources</td>
<td>Review the details of sources for both insurance and non-insurance data used as input to the model (only need sources for filed input characteristics included in the filed model).</td>
<td>1</td>
<td>Request details of data sources, whether internal to the company or from external sources. For insurance experience (policy or claim), determine whether data are aggregated by calendar, accident, fiscal, or policy year and when it was last evaluated. For each data source, get a list of all data elements used as input to the model that came from that source. For insurance data, get a list all companies whose data is included in the datasets. Request details of any non-insurance data used (customer-provided or other), whether the data was collected by use of a questionnaire/checklist, whether data was voluntarily reported by the applicant, and whether any of the data is subject to the federal Fair Credit Reporting Act (FCRA). If the data is from an outside source, find out what steps were taken to verify the data was accurate, complete, and unbiased in terms of relevant and representative time frame, representative of potential exposures, and lacking in obvious correlation to protected classes. <strong>Note:</strong> Reviewing source details should not make a difference when the model is new or refreshed; refreshed models would report the prior version list with the incremental changes due to the refresh.</td>
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<td>A.1.a</td>
<td>Reconcile aggregated insurance data underlying the model with available external insurance reports.</td>
<td>4</td>
<td>Accuracy of insurance data should be reviewed. It is assumed that the data in the insurer’s data banks is subject to routine internal company audits and reconciliation. “Aggregated data” is straight from the insurer’s data banks without further modification (i.e., not scrubbed or transformed for the purposes of modeling). In other words, the data would not have been specifically modified for the purpose of model building. The company should provide some form of reasonability check that the data makes sense when checked against other audited sources.</td>
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<td>A.1.c</td>
<td>Review the geographic scope and geographic exposure distribution of the raw data for relevance to the state where the model is filed.</td>
<td>2</td>
<td>Many models are developed using a countrywide or a regional dataset. The company should explain how the data used to build the model makes sense for a specific state. The regulator should inquire which states were included in the data underlying the model build, testing, and validation. The company should provide an explanation where the data came from geographically and that it is a good representation for a state; i.e., the distribution by state should not introduce a geographic bias. However, there could be a bias by peril or wind-resistant building codes. Evaluate whether the data is relevant to the loss potential for which it is being used. For example, verify that hurricane data is only used where hurricanes can occur.</td>
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<td>2. Sub-Models</td>
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<td>A.2.a</td>
<td>Consider the relevance of (i.e., whether there is bias) of overlapping data or variables used in the model and sub-models.</td>
<td>1</td>
<td>Check if the same variables/datasets were used in the model, a sub-model, or as stand-alone rating characteristics. If so, verify the insurance company has processes and procedures in place to assess and address double-counting or redundancy.</td>
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| A.2.b   | Determine if the sub-model was previously approved (or accepted) by the regulatory agency. | 1 | If the sub-model was previously approved/accepted, that may reduce the extent of the sub-model’s review. If approved, obtain the tracking number(s) (e.g., state, SERFF) and verify when and if it was the same model currently under review.  

**Note:** A previous approval does not necessarily confer a guarantee of ongoing approval; e.g., when statutes and/or regulations have changed or if a model’s indications have been undermined by subsequent empirical experience. However, knowing whether a model has been previously approved can help focus the regulator’s efforts and determine whether the prior decision needs to be revisited. In some circumstances, direct dialogue with the vendor could be quicker and more useful. |
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<tr>
<td>A.2.c</td>
<td>Determine if the sub-model output was used as input to the GLM; obtain the vendor name, as well as the name and version of the sub-model.</td>
<td>1</td>
<td>To accelerate the review of the filing, it may be desirable to request (from the company), the name and contact information for a vendor representative. The company should provide the name of the third-party vendor and a contact in the event the regulator has questions. The “contact” can be an intermediary at the insurer (e.g., a filing specialist), who can place the regulator in direct contact with a subject-matter expert (SME) at the vendor. Examples of such sub-models include credit/financial scoring algorithms and household composite score models. Sub-models can be evaluated separately and in the same manner as the primary model under evaluation. A sub-model contact for additional information should be provided. Sub-model SMEs may need to be brought into the conversation with regulators (whether in-house or third-party sub-models are used).</td>
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<td>A.2.d</td>
<td>If using catastrophe model output, identify the vendor and the model settings/assumptions used when the model was run.</td>
<td>1</td>
<td>To accelerate the review of the filing, get contact information for the SME that ran the model and an SME from the vendor. The “SME” can be an intermediary at the insurer (e.g., a filing specialist), who can place the regulator in direct contact with the appropriate SMEs at the insurer or model vendor. For example, it is important to know hurricane model settings for storm surge, demand surge, and long-term/short-term views.</td>
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<td>A.2.e</td>
<td>Obtain an explanation of how catastrophe models are integrated into the model to ensure no double-counting.</td>
<td>1</td>
<td>If a weather-based sub-model is input to the GLM under review, loss data used to develop the model should not include loss experience associated with the weather-based sub-model. Doing so could cause distortions in the modeled results by double-counting such losses when determining relativities or loss loads in the filed rating plan. For example, redundant losses in the data may occur when non-hurricane wind losses are included in the data while also using a severe convective storm model in the actuarial indication. Such redundancy may also occur with the inclusion of fluvial or pluvial flood losses when using a flood model or inclusion of freeze losses when using a winter storm model.</td>
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<td>A.2.f</td>
<td>If using output of any scoring algorithms, obtain a list of the variables used to determine the score and provide the source of the data used to calculate the score.</td>
<td>1</td>
<td>Any sub-model should be reviewed in the same manner as the primary model that uses the sub-model’s output as input. Depending on the result of item A.2.b, the importance of this item may be decreased.</td>
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<td>3. Adjustments to Data</td>
<td>Determine if premium, exposure, loss, or expense data were adjusted (e.g., developed, trended, adjusted for catastrophe experience, or capped). If so, how? Do the adjustments vary for different segments of the data? If so, identify the segments and how the data was adjusted.</td>
<td>2</td>
<td>The rating plan or indications underlying the rating plan may provide special treatment of large losses and non-modeled large loss events. If such treatments exist, the company should provide an explanation how they were handled. These treatments need to be identified and the company/regulator needs to determine whether model data needs to be adjusted. For example, should large bodily injury (BI) liability losses in the case of personal automobile insurance be excluded, or should large non-catastrophe wind/hail claims in home insurance be excluded from the model’s training, test and validation data? Look for anomalies in the data that should be addressed. For example, is there an extreme loss event in the data? If other processes were used to load rates for specific loss events, how is the impact of those losses considered? Examples of losses that can contribute to anomalies in the data are large losses or flood, hurricane, or severe convective storm losses for personal automobile comprehensive or home insurance.</td>
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<td></td>
<td>Identify adjustments that were made to aggregated data (e.g., transformations, binning and/or categorizations). If any, identify the name of the characteristic/variable and obtain a description of the adjustment.</td>
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<td></td>
<td>Ask for aggregated data (one dataset of pre-adjusted/scrubbed data and one dataset of post-adjusted/scrubbed data) that allows the regulator to focus on the univariate distributions and compare raw data to adjusted/binned/transformed/etc. data.</td>
<td>4</td>
<td>This is most relevant for variables that have been “scrubbed” or adjusted. Though most regulators may never ask for aggregated data and do not plan to rebuild any models, a regulator may ask for this aggregated data or subsets of it. It would be useful to the regulator if the percentage of exposures and premium for missing information from the model data by category are provided. This data can be displayed in either graphical or tabular formats.</td>
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<td>A.3.d</td>
<td>Determine how missing data was handled.</td>
<td>1</td>
<td>This is most relevant for variables that have been “scrubbed” or adjusted. The regulator should be aware of assumptions the modeler made in handling missing, null, or “not available” values in the data. For example, it would be helpful to the reviewer if the modeler were to provide a statement as to whether there is any systemic reason for missing data. If adjustments or recoding of values were made, they should be explained. It may also be useful to the regulator if the percentage of exposures and premium for missing information from the model data are provided. This data can be displayed in either graphical or tabular formats.</td>
</tr>
<tr>
<td>A.3.e</td>
<td>If duplicate records exist, determine how they were handled.</td>
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<tr>
<td>A.3.f</td>
<td>Determine if there were any material outliers identified and subsequently adjusted during the scrubbing process.</td>
<td>3</td>
<td>Look for a discussion of how outliers were handled. If necessary, the regulator may want to investigate further by getting a list (with description) of the types of outliers and determine what adjustments were made to each type of outlier. To understand the filer’s response, the regulator should ask for the filer’s materiality standard.</td>
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### 4. Data Organization

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<tbody>
<tr>
<td>A.4.a</td>
<td>Obtain documentation on the methods used to compile and organize data, including procedures to merge data from different sources or filter data based on particular characteristics and a description of any preliminary analyses, data checks, and logical tests performed on the data and the results of those tests.</td>
<td>2</td>
<td>This should explain how data from separate sources was merged and/or how subsets of policies, based on selected characteristics, are filtered to be included in the data underlying the model and the rationale for that filtering.</td>
</tr>
<tr>
<td>A.4.b</td>
<td>Obtain documentation on the insurer’s process for reviewing the appropriateness, reasonableness, consistency, and comprehensiveness of the data, including a discussion of the rational relationship the data has to the predicted variable.</td>
<td>2</td>
<td>An example is when by-peril or by-coverage modeling is performed; the documentation should be for each peril/coverage and make rational sense. For example, if “murder” or “theft” data are used to predict the wind peril, the company should provide support and a rational explanation for their use.</td>
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<tr>
<td>A.4.c</td>
<td>Identify material findings the company had during its data review and obtain an explanation of any potential material limitations, defects, bias, or unresolved concerns found or believed to exist in the data. If issues or limitations in the data influenced modeling analysis and/or results, obtain a description of those concerns and an explanation how modeling analysis was adjusted and/or results were impacted.</td>
<td>1</td>
<td>“None” or “N/A” may be an appropriate response.</td>
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## B. BUILDING THE MODEL

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<tr>
<td>1. High-Level Narrative for Building the Model</td>
<td>Identify the type of model underlying the rate filing (e.g., GLM, decision tree, Bayesian GLM, gradient-boosting machine, neural network, etc.). Understand the model’s role in the rating system and provide the reasons why that type of model is an appropriate choice for that role.</td>
<td>1</td>
<td>It is important to understand if the model in question is a GLM and, therefore, these information elements are applicable; or if it is some other model type, in which case other reasonable review approaches may be considered. There should be an explanation of why the model (using the variables included in it) is appropriate for the line of business. If by-peril or by-coverage modeling is used, the explanation should be by-peril/by-coverage. <strong>Note:</strong> If the model is not a GLM, the information elements in this white paper may not apply in their entirety.</td>
</tr>
<tr>
<td>B.1.a</td>
<td>Identify the software used for model development. Obtain the name of the software vendor/developer, software product, and a software version reference used in model development.</td>
<td>3</td>
<td>Changes in software from one model version to the next may explain if such changes, over time, contribute to changes in the modeled results. The company should provide the name of the third-party vendor and a “contact” in the event the regulator has questions. The “contact” can be an intermediary at the insurer (e.g., a filing specialist) who can place the regulator in direct contact with the appropriate SME at the vendor. Open-source software/programs used in model development should be identified by name and version the same as if from a vendor.</td>
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<tr>
<td>B.1.c</td>
<td>Obtain a description how the available data was divided between model training, test, and/or validation datasets. The description should include an explanation why the selected approach was deemed most appropriate, whether the company made any further subdivisions of available data, and reasons for the subdivisions (e.g., a portion separated from training data to support testing of components during model building). Determine if the validation data was accessed before model training was completed and, if so, obtain an explanation of why that came to occur. Obtain a discussion of whether the model was rebuilt using all the data or if it was only based on the training data.</td>
<td>1</td>
<td>The reviewer should be aware that modelers may break their data into three or just two datasets. Although the term “training” is used with little ambiguity, “test” and “validation” are terms that are sometimes interchanged, or the word “validation” may not be used at all. It would be unexpected if validation and/or test data were used for any purpose other than validation and/or test, prior to the selection of the final model. However, according to the CAS monograph, “Generalized Linear Models for Insurance Rating”: “Once a final model is chosen, … we would then go back and rebuild it using all of the data, so that the parameter estimates would be at their most credible.” The reviewer should note whether a company employed cross-validation techniques instead of a training/test/validation dataset approach. If cross-validation techniques were used, the reviewer should request a description of how cross-validation was done and confirm that the final model was not built on any particular subset of the data, but rather the full dataset.</td>
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<tr>
<td>B.1.d</td>
<td>Obtain a brief description of the development process, from initial concept to final model and filed rating plan.</td>
<td>1</td>
<td>The narrative should have the same scope as the filing.</td>
</tr>
<tr>
<td>B.1.c</td>
<td>Observe a narrative on whether loss ratio, pure premium, or frequency/severity analyses were performed and, if separate frequency/severity modeling was performed, how pure premiums were determined.</td>
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<tr>
<td>B.1.f</td>
<td>Identify the model’s target variable.</td>
<td>1</td>
<td>A clear description of the target variable is key to understanding the purpose of the model. It may also prove useful to obtain a sample calculation of the target variable in Excel format, starting with the “raw” data for a policy, or a small sample of policies, depending on the complexity of the target variable calculation.</td>
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<tr>
<td>B.1.g</td>
<td>Obtain a description of the variable selection process.</td>
<td>1</td>
<td>The narrative regarding the variable selection process may address matters such as the criteria upon which variables were selected or omitted, identification of the number of preliminary variables considered in developing the model versus the number of variables that remained, and any statutory or regulatory limitations that were taken into account when making the decisions regarding variable selection. The modeler should comment on the use of automated feature selection algorithms to choose predictor variables and explain how potential overfitting that can arise from these techniques was addressed.</td>
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<tr>
<td>B.1.h</td>
<td>In conjunction with variable selection, obtain a narrative on how the company determined the granularity of the rating variables during model development.</td>
<td>3</td>
<td>The narrative should include discussion of how credibility was considered in the process of determining the level of granularity of the variables selected.</td>
</tr>
<tr>
<td>B.1.i</td>
<td>Determine if model input data was segmented in any way (e.g., by-coverage, by-peril, or by-form basis). If so, obtain a description of data segmentation and the reasons for data segmentation.</td>
<td>1</td>
<td>The regulator would use this to follow the logic of the modeling process.</td>
</tr>
<tr>
<td>B.1.j</td>
<td>If adjustments to the model were made based on credibility considerations, obtain an explanation of the credibility considerations and how the adjustments were applied.</td>
<td>2</td>
<td>Adjustments may be needed, given that models do not explicitly consider the credibility of the input data or the model’s resulting output; models take input data at face value and assume 100% credibility when producing modeled output.</td>
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2. Medium-Level Narrative for Building the Model

B.2.a  | At crucial points in model development, if selections were made among alternatives regarding model assumptions or techniques, obtain a narrative on the judgment used to make those selections. | 3 |  |
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<tr>
<td>B.2.b</td>
<td>If post-model adjustments were made to the data and the model was rerun, obtain an explanation on the details and the rationale for those adjustments.</td>
<td>2</td>
<td>Evaluate the addition or removal of variables and the model fitting. It is not necessary for the company to discuss each iteration of adding and subtracting variables, but the regulator should gain a general understanding of how these adjustments were done, including any statistical improvement measures relied upon.</td>
</tr>
<tr>
<td>B.2.c</td>
<td>Obtain a description of the testing that was performed during the model-building process, including an explanation of the decision-making process to determine which interactions were included and which were not.</td>
<td>3</td>
<td>There should be a description of the testing that was performed during the model-building process. Examples of tests that may have been performed include univariate testing and review of a correlation matrix. The number of interaction terms that could potentially be included in a model increases far more quickly than the number of “main effect” variables (i.e., the basic predictor variables that can be interacted together). Analyzing each possible interaction term individually can be unwieldy. It is typical for interaction terms to be excluded from the model by default, and only included where they can be shown to be particularly important. So, as a rule of thumb, the regulator’s emphasis should be on understanding why the insurer included the interaction terms it did, rather than on why other candidate interactions were excluded. In some cases, however, it could be reasonable to inquire about why a particular interaction term was excluded from a model—for example, if that interaction term was ubiquitous in similar filings and was known to be highly predictive, or if the regulator had reason to believe that the interaction term would help differentiate dissimilar risks within an excessively heterogenous rating segment.</td>
</tr>
<tr>
<td>B.2.d</td>
<td>For the GLM, identify the link function used. Identify which distribution was used for the model (e.g., Poisson, Gaussian, log-normal, Tweedie). Obtain an explanation of why the link function and distribution were chosen. Obtain the formulas for the distribution and link functions, including specific numerical parameters of the distribution. If changed from the default, obtain a discussion of applicable convergence criterion.</td>
<td>1</td>
<td>Solving the GLM is iterative and the modeler can check to see if fit is improving. At some point, convergence occurs; however, when it occurs can be subjective or based on threshold criteria. If the software’s default convergence criteria were not relied upon, an explanation of any deviation should be provided.</td>
</tr>
<tr>
<td>B.2.e</td>
<td>Obtain a narrative on the formula relationship between the data and the model outputs, with a definition of each model input and output. The narrative should include all coefficients necessary to evaluate the predicted pure premium, relativity, or other value, for any real or hypothetical set of inputs.</td>
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<tr>
<td>B.2.f</td>
<td>If there were data situations in which GLM weights were used, obtain an explanation of how and why they were used.</td>
<td>3</td>
<td>Investigate whether identical records were combined to build the model.</td>
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<td>3. Predictor Variables</td>
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<tr>
<td>B.3.a</td>
<td>Obtain a complete data dictionary, including the names, types, definitions, and uses of each predictor variable, offset variable, control variable, proxy variable, geographic variable, geodemographic variable, and all other variables in the model used on their own or as an interaction with other variables (including sub-models and external models).</td>
<td>1</td>
<td>Types of variables might be continuous, discrete, Boolean, etc. Definitions should not use programming language or code. For any variable(s) intended to function as a control or offset, obtain an explanation of its purpose and impact. Also, for any use of interaction between variables, obtain an explanation of its rationale and impact.</td>
</tr>
<tr>
<td>B.3.b</td>
<td>Obtain a list of predictor variables considered but not used in the final model, and the rationale for their removal.</td>
<td>4</td>
<td>The purpose of this requirement is to identify variables the company finds to be predictive but ultimately may reject for reasons other than loss-cost considerations (e.g., price optimization). Also, look for variables the company tested and then rejected. This item could help address concerns about data dredging. The reasonableness of including a variable with a given significance level could depend greatly on the other variables the company evaluated for inclusion in the model and the criteria for inclusion or omission. For instance, if the company tested 1,000 similar variables and selected the one with the lowest p-value of 0.001, this would be a far, far weaker case for statistical significance than if that variable was the only one the company evaluated. <strong>Note:</strong> Context matters.</td>
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<tr>
<td>B.3.c</td>
<td>Obtain a correlation matrix for all predictor variables included in the model and sub-model(s).</td>
<td>3</td>
<td>While GLMs accommodate collinearity, the correlation matrix provides more information about the magnitude of correlation between variables. The company should indicate what statistic was used (e.g., Pearson, Cramer’s V). The regulatory reviewer should understand what statistic was used to produce the matrix but should not prescribe the statistic.</td>
</tr>
<tr>
<td>B.3.d</td>
<td>Obtain a rational explanation for why an increase in each predictor variable should increase or decrease frequency, severity, loss costs, expenses, or any element or characteristic being predicted.</td>
<td>3</td>
<td>The explanation should go beyond demonstrating correlation. Considering possible causation may be relevant, but proving causation is neither practical nor expected. If no rational explanation can be provided, greater scrutiny may be appropriate. For example, the regulator should look for unfamiliar predictor variables and, if found, the regulator should seek to understand the connection that variable has to increasing or decreasing the target variable.</td>
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<td>B.3.e</td>
<td>If the modeler made use of one or more dimensionality reduction techniques, such as a principal component analysis (PCA), obtain a narrative about that process, an explanation why that technique was chosen, and a description of the step-by-step process used to transform observations (usually correlated) into a set of linearly uncorrelated variables. In each instance, obtain a list of the pre-transformation and post-transformation variable names, as well as an explanation of how the results of the dimensionality reduction technique was used within the model.</td>
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4. Adjusting Data, Model Validation, and Goodness-of-Fit Measures

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<tr>
<td>B.4.a</td>
<td>Obtain a description of the methods used to assess the statistical significance/goodness-of-fit of the model to validation data, such as lift charts and statistical tests. Compare the model’s projected results to historical actual results and verify that modeled results are reasonably similar to actual results from validation data.</td>
<td>1</td>
<td>For models that are built using multistate data, validation data for some segments of risk is likely to have low credibility in individual states. Nevertheless, some regulators require model validation on state-only data, especially when analysis using state-only data contradicts the countrywide results. State-only data might be more applicable but could also be impacted by low credibility for some segments of risk. Note: It may be useful to consider geographic stability measures for territories within the state.</td>
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<tr>
<td>B.4.b</td>
<td>For all variables (discrete or continuous), review the appropriate parameter values and relevant tests of significance, such as confidence intervals, chi-square tests, p-values, or F tests. Determine if model development data, validation data, test data, or other data was used for these tests.</td>
<td>1</td>
<td>Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model. Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values, and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; e.g., confidence intervals around each level of an AOI curve might be more than what is needed.</td>
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<td>B.4.c</td>
<td>Identify the threshold for statistical significance and explain why it was selected. Obtain a reasonable and appropriately supported explanation for keeping the variable for each discrete variable level where the p-values were not less than the chosen threshold.</td>
<td>1</td>
<td>The explanation should clearly identify the thresholds for statistical significance used by the modeler. Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model. Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values, and any other relevant and material tests.</td>
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<tr>
<td>B.4.d</td>
<td>For overall discrete variables, review type 3 chi-square tests, p-values, F tests and any other relevant and material test. Determine if model development data, validation data, test data, or other data was used for these tests.</td>
<td>2</td>
<td>Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model. Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values, and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; e.g., confidence intervals around each level of an AOI curve might be more than what is needed.</td>
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<tr>
<td>B.4.e</td>
<td>Obtain evidence that the model fits the training data well, for individual variables, for any relevant combinations of variables, and for the overall model.</td>
<td>2</td>
<td>For a GLM, such evidence may be available using chi-square tests, p-values, F tests and/or other means. The steps taken during modeling to achieve goodness-of-fit are likely to be numerous and laborious to describe, but they contribute much of what is generalized about a GLM. The regulator should not assume to know what the company did and ask, “How?” Instead, the regulator should ask what the company did and be prepared to ask follow-up questions.</td>
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<tr>
<td>B.4.f</td>
<td>For continuous variables, provide confidence intervals, chi-square tests, p-values, and any other relevant and material test. Determine if model development data, validation data, test data, or other data was used for these tests.</td>
<td>2</td>
<td>Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model. Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an AOI curve might be more than what is needed.</td>
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<tr>
<td>B.4.g</td>
<td>Obtain a description how the model was tested for stability over time.</td>
<td>2</td>
<td>Evaluate the build/test/validation datasets for potential time-sensitive model distortions (e.g., a winter storm in year 3 of 5 can distort the model in both the testing and validation datasets). Obsolescence over time is a model risk (e.g., old data for a variable or a variable itself may no longer be relevant). If a model being introduced now is based on losses from years ago, the reviewer should be interested in knowing whether that model would be predictive in the proposed context. Validation using recent data from the proposed context might be requested. Obsolescence is a risk even for a new model based on recent and relevant loss data. The reviewer may want to inquire as to the following: What steps, if any, were taken during modeling to prevent or delay obsolescence? What controls exist to measure the rate of obsolescence? What is the plan and timeline for updating and ultimately replacing the model? The reviewer should also consider that as newer technologies enter the market (e.g., personal automobile) their impact may change claim activity over time (e.g., lower frequency of loss). So, it is not necessarily a bad thing that the results are not stable over time.</td>
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<td>B.4.h</td>
<td>Obtain a narrative on how potential concerns with overfitting were addressed.</td>
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<td>B.4.i</td>
<td>Obtain support demonstrating that the GLM assumptions are appropriate.</td>
<td>3</td>
<td>A visual review of plots of actual errors is usually sufficient. The reviewer should look for a conceptual narrative covering these topics: How does this particular GLM work? Why did the rate filer do what it did? Why employ this design instead of alternatives? Why choose this particular distribution function and this particular link function? A company response may be at a fairly high level and reference industry practices. If the reviewer determines that the model makes no assumptions that are considered to be unreasonable, the importance of this item may be reduced.</td>
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<tr>
<td>B.4.j</td>
<td>Obtain 5-10 sample records with corresponding output from the model for those records.</td>
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5. “Old Model” Versus “New Model”

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<tr>
<td>B.5.a</td>
<td>Obtain an explanation of why this model is an improvement to the current rating plan. If it replaces a previous model, find out why it is better than the one it is replacing; determine how the company reached that conclusion and identify metrics relied on in reaching that conclusion. Look for an explanation of any changes in calculations, assumptions, parameters, and data used to build this model from the previous model.</td>
<td>2</td>
<td>The regulator should expect to see improvement in the new class plan’s predictive ability or other sufficient reason for the change.</td>
</tr>
<tr>
<td>B.5.b</td>
<td>Determine if two Gini coefficients were compared and obtain a narrative on the conclusion drawn from this comparison.</td>
<td>3</td>
<td>This information element requests a comparison of Gini coefficient from the prior model to the Gini coefficient of proposed model. It is expected that there should be improvement in the Gini coefficient. A higher Gini coefficient indicates greater differentiation produced by the model and how well the model fits that data. This is relevant when one model is being updated or replaced. The regulator should expect to see improvement in the new class plan’s predictive ability. One example of a comparison might be sufficient. Note: This comparison is not applicable to initial model introduction. Reviewer can look to CAS monograph, “Generalized Linear Models for Insurance Rating.”</td>
</tr>
<tr>
<td>B.5.c</td>
<td>Determine if double-lift charts were analyzed and obtain a narrative on the conclusion drawn from this analysis.</td>
<td>3</td>
<td>One example of a comparison might be sufficient. Note: “Not applicable” is an acceptable response.</td>
</tr>
<tr>
<td>Section</td>
<td>Information Element</td>
<td>Level of Importance to Regulator’s Review</td>
<td>Comments</td>
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<tr>
<td>B.5.d</td>
<td>If replacing an existing model, obtain a list of any predictor variables used in the old model that are not used in the new model. Obtain an explanation of why these variables were dropped from the new model. Obtain a list of all new predictor variables in the new model that were not in the prior old model.</td>
<td>2</td>
<td>It is useful to differentiate between old and new variables, so the regulator can prioritize more time on variables not yet reviewed.</td>
</tr>
<tr>
<td>6. Modeler Software</td>
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<tr>
<td>B.6.a</td>
<td>Request access to SMEs (e.g., modelers) who led the project, compiled the data, and/or built the model.</td>
<td>4</td>
<td>The filing should contain a contact that can put the regulator in touch with appropriate SMEs and key contributors to the model development to discuss the model.</td>
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</tbody>
</table>
## C. THE FILED RATING PLAN

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<th>Information Element</th>
<th>Level of Importance to Regulator’s Review</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>1. General Impact of Model on Rating Algorithm</td>
<td></td>
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</tr>
<tr>
<td>C.1.a</td>
<td>In the actuarial memorandum or explanatory memorandum, for each model and sub-model (including external models), look for a narrative that explains each model and its role (i.e., how it was used) in the rating system.</td>
<td>1</td>
<td>The “role of the model” relates to how the model integrates into the rating plan as a whole and where the effects of the model are manifested within the various components of the rating plan. This is not intended as an overarching statement of the model’s goal, but rather a description of how specifically the model is used. This item is particularly important, if the role of the model cannot be immediately discerned by the reviewer from a quick review of the rate and/or rule pages. (Importance is dependent on state requirements and ease of identification by the first layer of review and escalation to the appropriate review staff.)</td>
</tr>
<tr>
<td>C.1.b</td>
<td>Obtain an explanation of how the model was used to adjust the filed rating algorithm.</td>
<td>1</td>
<td>Models are often used to produce factor-based indications, which are then used as the basis for the selected changes to the rating plan. It is the changes to the rating plan that create impacts. The regulator should consider asking for an explanation of how the model was used to adjust the rating algorithm.</td>
</tr>
<tr>
<td>C.1.c</td>
<td>Obtain a complete list of characteristics/variables used in the proposed rating plan, including those used as input to the model (including sub-models and composite variables) and all other characteristics/variables (not input to the model) used to calculate a premium. For each characteristic/variable, determine if it is only input to the model, whether it is only a separate univariate rating characteristic, or whether it is both input to the model and a separate univariate rating characteristic. The list should include transparent descriptions (in plain language) of each listed characteristic/variable.</td>
<td>1</td>
<td>Examples of variables used as inputs to the model and used as separate univariate rating characteristics might be criteria used to determine a rating tier or household composite characteristic.</td>
</tr>
<tr>
<td>Section</td>
<td>Information Element</td>
<td>Level of Importance to Regulator's Review</td>
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<tr>
<td><strong>2. Relevance of Variables and Relationship to Risk of Loss</strong></td>
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<tr>
<td>C.2.a</td>
<td>Obtain a narrative regarding how the characteristics/rating variables included in the filed rating plan relate to the risk of insurance loss (or expense) for the type of insurance product being priced.</td>
<td>2</td>
<td>The narrative should include a discussion of the relevance each characteristic/rating variable has on consumer behavior that would lead to a difference in risk of loss (or expense). The narrative should include a rational relationship to cost, and model results should be consistent with the expected direction of the relationship. Note: This explanation would not be needed if the connection between variables and risk of loss (or expense) has already been illustrated.</td>
</tr>
<tr>
<td><strong>3. Comparison of Model Outputs to Current and Selected Rating Factors</strong></td>
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<tr>
<td>C.3.a</td>
<td>Compare relativities indicated by the model to both current relativities and the insurer’s selected relativities for each risk characteristic/variable in the rating plan.</td>
<td>1</td>
<td>“Significant difference” may vary based on the risk characteristic/variable and context. However, the movement of a selected relativity should be in the direction of the indicated relativity; if not, an explanation is necessary as to why the movement is logical.</td>
</tr>
<tr>
<td>C.3.b</td>
<td>Obtain documentation and support for all calculations, judgments, or adjustments that connect the model’s indicated values to the selected relativities filed in the rating plan.</td>
<td>1</td>
<td>The documentation should include explanations for the necessity of any such adjustments and each significant difference between the model’s indicated values and the selected values. This applies even to models that produce scores, tiers, or ranges of values for which indications can be derived. Note: This information is especially important if differences between model-indicated values and selected values are material and/or impact one consumer population more than another.</td>
</tr>
<tr>
<td>C.3.c</td>
<td>For each characteristic/variable used as both input to the model (including sub-models and composite variables) and as a separate univariate rating characteristic, obtain a narrative regarding how each characteristic/variable was tempered or adjusted to account for possible overlap or redundancy in what the characteristic/variable measures.</td>
<td>2</td>
<td>Modeling loss ratios with these characteristics/variables as control variables would account for possible overlap. The insurer should address this possibility or other considerations; e.g., tier placement models often use risk characteristics/variables that are also used elsewhere in the rating plan. One way to do this would be to model the loss ratios resulting from a process that already uses univariate rating variables. Then the model/composite variables would be attempting to explain the residuals.</td>
</tr>
<tr>
<td>Section</td>
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<tr>
<td>4. Responses to Data, Credibility, and Granularity Issues</td>
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<tr>
<td>C.4.a</td>
<td>Determine what, if any, consideration was given to the credibility of the output data.</td>
<td>2</td>
<td>The regulator should determine at what level of granularity credibility is applied. If modeling was by-coverage, by-form, or by-peril, the company should explain how these were handled when there was not enough credible data by coverage, form, or peril to model.</td>
</tr>
<tr>
<td>C.4.b</td>
<td>If the rating plan is less granular than the model, obtain an explanation of why.</td>
<td>2</td>
<td>This is applicable if the company had to combine modeled output in order to reduce the granularity of the rating plan.</td>
</tr>
<tr>
<td>C.4.c</td>
<td>If the rating plan is more granular than the model, obtain an explanation of why.</td>
<td>2</td>
<td>A more granular rating plan may imply that the company had to extrapolate certain rating treatments, especially at the tails of a distribution of attributes, in a manner not specified by the model indications. It may be necessary to extrapolate due to data availability or other considerations.</td>
</tr>
<tr>
<td>5. Definitions of Rating Variables</td>
<td></td>
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<tr>
<td>C.5.a</td>
<td>Obtain a narrative regarding adjustments made to model output (e.g., transformations, binning and/or categorizations). If adjustments were made, obtain the name of the characteristic/variable and a description of the adjustment.</td>
<td>2</td>
<td>If rating tiers or other intermediate rating categories are created from model output, the rate and/or rule pages should present these rating tiers or categories. The company should provide an explanation of how model output was translated into these rating tiers or intermediate rating categories.</td>
</tr>
<tr>
<td>6. Supporting Data</td>
<td></td>
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<tr>
<td>C.6.a</td>
<td>Obtain aggregated state-specific, book-of-business-specific univariate historical experience data, separately for each year included in the model, consisting of loss ratio or pure premium relativities and the data underlying those calculations for each category of model output(s) proposed to be used within the rating plan. For each data element, obtain an explanation of whether it is raw or adjusted and, if the latter, obtain a detailed explanation for the adjustments.</td>
<td>4</td>
<td>For example, were losses developed/undeveloped, trended/untrended, capped/uncapped, etc.? Univariate indications should not necessarily be used to override more sophisticated multivariate indications. However, they do provide additional context and may serve as a useful reference.</td>
</tr>
<tr>
<td>Section</td>
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<td>Level of Importance to Regulator’s Review</td>
<td>Comments</td>
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</tr>
<tr>
<td>C.6.b</td>
<td>Obtain an explanation of any material (especially directional) differences between model indications and state-specific univariate indications.</td>
<td>4</td>
<td>Multivariate indications may be reasonable as refinements to univariate indications, but possibly not for bringing about significant reversals of those indications. For instance, if the univariate indicated relativity for an attribute is 1.5 and the multivariate indicated relativity is 1.25, this is potentially a plausible application of the multivariate techniques. If, however, the univariate indicated relativity is 0.7 and the multivariate indicated relativity is 1.25, a regulator may question whether the attribute in question is negatively correlated with other determinants of risk. Credibility of state-level data should be considered when state indications differ from modeled results based on a broader dataset. However, the relevance of the broader dataset to the risks being priced should also be considered. Borderline reversals are not of as much concern. If multivariate indications perform well against the state-level data, this should suffice. However, credibility considerations need to be taken into account as state-level segmentation comparisons may not have enough credibility.</td>
</tr>
<tr>
<td>7. Consumer Impacts</td>
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<tr>
<td>C.7.a</td>
<td>Obtain a listing of the top five rating variables that contribute the most to large swings in renewal premium, both as increases and decreases, as well as the top five rating variables with the largest spread of impact for both new and renewal business.</td>
<td>4</td>
<td>These rating variables may represent changes to rating factors, be newly introduced to the rating plan, or have been removed from the rating plan.</td>
</tr>
<tr>
<td>C.7.b</td>
<td>Determine if the company performed sensitivity testing to identify significant changes in premium due to small or incremental change in a single risk characteristic. If such testing was performed, obtain a narrative that discusses the testing and provides the results of that testing.</td>
<td>3</td>
<td>One way to see sensitivity is to analyze a graph of each risk characteristic’s/variable’s possible relativities. Look for significant variation between adjacent relativities and evaluate if such variation is reasonable and credible.</td>
</tr>
<tr>
<td>C.7.c</td>
<td>For the proposed filing, obtain the impacts on renewal business and describe the process used by management, if any, to mitigate those impacts.</td>
<td>2</td>
<td>Some mitigation efforts may substantially weaken the connection between premium and expected loss and expense and, hence, may be viewed as unfairly discriminatory by some states.</td>
</tr>
<tr>
<td>Section</td>
<td>Information Element</td>
<td>Level of Importance to Regulator’s Review</td>
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<tr>
<td>C.7.d</td>
<td>Obtain a rate disruption/dislocation analysis, demonstrating the distribution of percentage and/or dollar impacts on renewal business (created by rerating the current book of business) and sufficient information to explain the disruptions to individual consumers.</td>
<td>2</td>
<td>The analysis should include the largest dollar and percentage impacts arising from the filing, including the impacts arising specifically from the adoption of the model or changes to the model as they translate into the proposed rating plan. While the default request would typically be for the distribution/dislocation of impacts at the overall filing level, the regulator may need to delve into the more granular variable-specific effects of rate changes if there is concern about particular variables having extreme or disproportionate impacts, or significant impacts that have otherwise yet to be substantiated. See Appendix D for an example of a disruption analysis.</td>
</tr>
<tr>
<td>C.7.e</td>
<td>Obtain exposure distributions for the model’s output variables and show the effects of rate changes at granular and summary levels, including the overall impact on the book of business.</td>
<td>3</td>
<td>See Appendix D for an example of an exposure distribution.</td>
</tr>
<tr>
<td>C.7.f</td>
<td>Identify policy characteristics, used as input to a model or sub-model, that remain “static” over a policy’s lifetime versus those that will be updated periodically. Obtain a narrative on how the company handles policy characteristics that are listed as “static,” yet change over time.</td>
<td>3</td>
<td>Some examples of “static” policy characteristics are prior carrier tenure, prior carrier type, prior liability limits, claim history over past X years, or lapse of coverage. These are specific policy characteristics usually set at the time new business is written, used to create an insurance score or to place the business in a rating/underwriting tier, and often fixed for the life of the policy. The reviewer should be aware, and possibly concerned, how the company treats an insured over time when the insured’s risk profile based on “static” variables changes over time but the rate charged, based on a new business insurance score or tier assignment, no longer reflect the insured’s true and current risk profile. A few examples of “non-static” policy characteristics are age of driver, driving record, and credit information (FCRA-related). These are updated automatically by the company on a periodic basis, usually at renewal, with or without the policyholder explicitly informing the company.</td>
</tr>
<tr>
<td>Section</td>
<td>Information Element</td>
<td>Level of Importance to Regulator’s Review</td>
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<tr>
<td>C.7.g</td>
<td>Obtain a means to calculate the rate charged a consumer.</td>
<td>3</td>
<td>The filed rating plan should contain enough information for a regulator to be able to validate policy premium. However, for a complex model or rating plan, a score or premium calculator via Excel or similar means would be ideal, but this could be elicited on a case-by-case basis. The ability to calculate the rate charged could allow the regulator to perform sensitivity testing when there are small changes to a risk characteristic/variable. Note: This information may be proprietary. For the rating plan, the rate order of calculation rule may be sufficient. However, it may not be feasible for a regulator to get all the input data necessary to reproduce a model’s output. Credit and telematics models are examples of model types where model output would be readily available, but the input data would not be readily available to the regulator.</td>
</tr>
<tr>
<td>C.7.h</td>
<td>In the filed rating plan, be aware of any non-insurance data used as input to the model (customer-provided or other). In order to respond to consumer inquiries, it may be necessary to inquire as to how consumers can verify their data and correct errors.</td>
<td>1</td>
<td>If the data is from a third-party source, the company should provide information on the source. Depending on the nature of the data, it may need to be documented with an overview of who owns it. The topic of consumer verification may also need to be addressed, including how consumers can verify their data and correct errors.</td>
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</table>

**8. Accurate Translation of Model into a Rating Plan**

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<th>Section</th>
<th>Information Element</th>
<th>Level of Importance to Regulator’s Review</th>
<th>Comments</th>
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<tbody>
<tr>
<td>C.8.a</td>
<td>Obtain sufficient information to understand how the model outputs are used within the rating system and to verify that the rating plan’s manual, in fact, reflects the model output and any adjustments made to the model output.</td>
<td>1</td>
<td>The regulator can review the rating plan’s manual to see that modeled output is properly reflected in the manual’s rules, rates, factors, etc.</td>
</tr>
<tr>
<td>Section</td>
<td>Information Element</td>
<td>Level of Importance to Regulator's Review</td>
<td>Comments</td>
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<tr>
<td>9. Efficient and Effective Review of Rate Filing</td>
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<tr>
<td>C.9.a</td>
<td>Establish procedures to efficiently review rate filings and models contained therein.</td>
<td>1</td>
<td>“Speed to market” is an important competitive concept for insurers. Although the regulator needs to understand the rate filing before accepting the rate filing, the regulator should not request information that does not increase his/her understanding of the rate filing. The regulator should review the state’s rate filing review process and procedures to ensure that they are fair and efficient.</td>
</tr>
<tr>
<td>C.9.b</td>
<td>Be knowledgeable of state laws and regulations in order to determine if the proposed rating plan (and models) are compliant with state laws and/or regulations.</td>
<td>1</td>
<td>This is a primary duty of state insurance regulators. The regulator should be knowledgeable of state laws and regulations and apply them to a rate filing fairly and efficiently. The regulator should pay special attention to prohibitions of unfair discrimination.</td>
</tr>
<tr>
<td>C.9.c</td>
<td>Be knowledgeable of state laws and regulations in order to determine if any information contained in the rate filing (and models) should be treated as confidential.</td>
<td>1</td>
<td>The regulator should be knowledgeable of state laws and regulations regarding confidentiality of rate filing information and apply them to a rate filing fairly and efficiently. Confidentiality of proprietary information is key to innovation and competitive markets.</td>
</tr>
</tbody>
</table>
APPENDIX B (Continued)

Mapping Best Practices to Information Elements and Information Elements to Best Practices

Table 1 maps the best practices to each GLM information element. Table 2 maps the GLM information elements to each best practice. With this mapping, a state insurance regulator interested in how to meet the objective of a best practice can consider the information elements associated with the best practice in the table.

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<thead>
<tr>
<th>Appendix B: Table 1</th>
<th>Best Practices Mapped to Information Element</th>
</tr>
</thead>
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<td>Information Element</td>
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<tr>
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<tr>
<td>A.1. Available Data Sources</td>
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<tr>
<td>A.1.a</td>
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<td>A.1.b</td>
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<td>A.1.c</td>
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<tr>
<td>A.2. Sub-Models</td>
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<tr>
<td>A.2.a</td>
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<td>A.2.b</td>
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<td>A.2.c</td>
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<td>A.2.d</td>
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<td>A.2.e</td>
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<td>A.2.f</td>
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<tr>
<td>A.3. Adjustments to Data</td>
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<td>A.3.a</td>
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<td>A.3.b</td>
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<td>A.3.c</td>
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<td>A.3.f</td>
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<tr>
<td>A.4. Data Organization</td>
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<td>A.4.a</td>
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<td>A.4.b</td>
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<td>A.4.c</td>
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<tr>
<td><strong>B. Building the Model</strong></td>
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<tr>
<td>B.1. High-Level Narrative for Building the Model</td>
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<td>B.1.b</td>
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<td>B.1.c</td>
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<td>B.1.d</td>
<td></td>
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<tr>
<td>Information Element</td>
<td>Selected Best Practices Mapped to Information Element</td>
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<tr>
<td>B.1.e</td>
<td>2.a</td>
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<tr>
<td>B.1.f</td>
<td>1.b, 2.a</td>
</tr>
<tr>
<td>B.1.g</td>
<td>1.b, 1.d, 2.a, 3.a</td>
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<tr>
<td>B.1.h</td>
<td>2.a, 2.b</td>
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<tr>
<td>B.1.i</td>
<td>1.b, 2.a</td>
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<tr>
<td>B.1.j</td>
<td>2.a, 2.c</td>
</tr>
</tbody>
</table>

**B.2. Medium-Level Narrative for Building the Model**

| B.2.a               | 2.a                                                  |
| B.2.b               | 2.a, 2.c                                             |
| B.2.c               | 2.a, 3.b                                             |
| B.2.d               | 2.a                                                  |
| B.2.e               | 2.a, 3.a, 3.b                                        |
| B.2.f               | 2.a, 2.c                                             |

**B.3. Predictor Variables**

| B.3.a               | 1.b, 1.d, 2.a, 3.a                                   |
| B.3.b               | 2.a                                                  |
| B.3.c               | 1.d, 2.a, 3.a                                        |
| B.3.d               | 1.b, 1.d, 3.a                                        |
| B.3.e               | 2.a, 3.a                                             |

**B.4. Adjusting Data, Model Validation, and Goodness-of-Fit Measures**

| B.4.a               | 2.a, 3.b                                             |
| B.4.b               | 2.a, 3.b                                             |
| B.4.c               | 1.b, 2.a                                             |
| B.4.d               | 1.b, 2.a, 2.b, 3.b                                   |
| B.4.e               | 1.b, 2.a                                             |
| B.4.f               | 1.b, 2.a, 3.b                                        |
| B.4.g               | 2.a, 2.d, 3.b                                        |
| B.4.h               | 2.a                                                  |
| B.4.i               | 1.b, 2.a                                             |
| B.4.j               | 1.d, 2.a, 3.c                                        |

**B.5. “Old Model” Versus “New Model”**

| B.5.a               | 3.b                                                  |
| B.5.b               | 2.a, 3.b                                             |
### Appendix B: Table 1
**Best Practices Mapped to Information Element**

<table>
<thead>
<tr>
<th>Information Element</th>
<th>Selected Best Practices Mapped to Information Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.5.c</td>
<td>2.a, 3.b</td>
</tr>
<tr>
<td>B.5.d</td>
<td>2.d, 3.a, 3.b</td>
</tr>
<tr>
<td>B.6. Modeler Software</td>
<td></td>
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<tr>
<td>B.6.a</td>
<td>2.a</td>
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<td>C. The Filed Rating Plan</td>
<td></td>
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<tr>
<td>C.1. General Impact of Model on Rating Algorithm</td>
<td></td>
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<tr>
<td>C.1.a</td>
<td>2.a, 3.b</td>
</tr>
<tr>
<td>C.1.b</td>
<td>3.b, 3.c</td>
</tr>
<tr>
<td>C.1.c</td>
<td>1.b, 1.d, 3.a, 3.c</td>
</tr>
<tr>
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<td>C.7.b</td>
<td>1.a, 1.c</td>
</tr>
<tr>
<td>C.7.c</td>
<td>1.a, 1.c, 3.b</td>
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<td>C.7.d</td>
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<td>C.7.e</td>
<td>1.a, 1.c</td>
</tr>
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<td>C.7.f</td>
<td>2.d</td>
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</table>

© 2021 National Association of Insurance Commissioners
<table>
<thead>
<tr>
<th>Information Element</th>
<th>Selected Best Practices Mapped to Information Element</th>
</tr>
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<tbody>
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<td>C.8.a</td>
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<tr>
<td>C.9.c</td>
<td>4.a, 4.b, 4.c</td>
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<tr>
<td>Best Practice</td>
<td>Best Practice Code</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>1. Ensure that the factors developed based on the model produce rates that are not excessive, inadequate, or unfairly discriminatory.</td>
<td></td>
</tr>
<tr>
<td>a. Review the overall rate level impact of the proposed revisions to rate level indications provided by the filer.</td>
<td>1.a</td>
</tr>
<tr>
<td>b. Determine whether individual input characteristics to a predictive model and their resulting rating factors are related to the expected loss or expense differences in risk.</td>
<td>1.b</td>
</tr>
<tr>
<td>c. Review the premium disruption for individual policyholders and how the disruptions can be explained to individual consumers.</td>
<td>1.c</td>
</tr>
<tr>
<td>d. Review the individual input characteristics to and output factors from the predictive model (and its sub-models), as well as associated selected relativities, to ensure they are compatible with practices allowed in the state and do not reflect prohibited characteristics.</td>
<td>1.d</td>
</tr>
<tr>
<td>2. Obtain a clear understanding of the data used to build and validate the model and thoroughly review all aspects of the model, including assumptions, adjustments, variables, sub-models used as input, and resulting output.</td>
<td></td>
</tr>
<tr>
<td>a. Obtain a clear understanding of how the selected predictive model was built.</td>
<td>2.a</td>
</tr>
<tr>
<td>b. Determine whether the data used as input to the predictive model is accurate, including a clear understanding how missing values, erroneous values, and outliers are handled.</td>
<td>2.b</td>
</tr>
<tr>
<td>c. Determine whether any adjustments to the raw data are handled appropriately, including, but not limited to, trending, development, capping, and removal of catastrophes.</td>
<td>2.c</td>
</tr>
</tbody>
</table>
### Appendix B: Table 2

Information Element Mapped to Best Practices

<table>
<thead>
<tr>
<th>Best Practice</th>
<th>Best Practice Code</th>
<th>Information Element (for GLMs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>d. Obtain a clear understanding of how often each risk characteristic used as input to the model is updated and whether the model is periodically refreshed, so model output reflects changes to non-static risk characteristics.</td>
<td>2.d</td>
<td>A.2.c, A.2.d, B.4.g, B.5.d, C.7.f, C.7.h</td>
</tr>
<tr>
<td>3. Evaluate how the model interacts with and improves the rating plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Obtain a clear understanding of the characteristics that are input to a predictive model (and its sub-models).</td>
<td>3.a</td>
<td>A.1.a, A.2.a, A.2.c, A.2.d, A.2.e, A.2.f, A.4.a, B.1.g, B.2.e, B.3.a, B.3.c, B.3.d, B.3.e, B.5.d, C.1.c, C.2.a, C.3.c, C.7.h</td>
</tr>
<tr>
<td>b. Obtain a clear understanding of how the insurer integrates the model into the rating plan and how it improves the rating plan.</td>
<td>3.b</td>
<td>B.1.d, B.2.c, B.2.e, B.4.a, B.4.b, B.4.d, B.4.f, B.4.g, B.5.a, B.5.b, B.5.c, B.5.d, C.1.a, C.1.b, C.3.a, C.3.b, C.3.c, C.4.a, C.4.b, C.4.c, C.5.a, C.6.b, C.7.c, C.7.g, C.7.h, C.8.a</td>
</tr>
<tr>
<td>c. Obtain a clear understanding of how the model output interacts with non-modeled characteristics/variables used to calculate a risk’s premium.</td>
<td>3.c</td>
<td>A.2.a, B.4.j, C.1.b, C.1.c, C.3.c, C.5.a, C.8.a</td>
</tr>
<tr>
<td>4. Enable competition and innovation to promote the growth, financial stability, and efficiency of the insurance marketplace.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Enable innovation in the pricing of insurance through acceptance of predictive models, provided they are in compliance with state laws and/or regulations, particularly prohibitions on unfair discrimination.</td>
<td>4.a</td>
<td>C.9.a, C.9.b, C.9.c</td>
</tr>
<tr>
<td>b. Protect the confidentiality of filed predictive models and supporting information in accordance with state laws and/or regulations.</td>
<td>4.b</td>
<td>C.9.a, C.9.b, C.9.c</td>
</tr>
<tr>
<td>c. Review predictive models in a timely manner to enable reasonable speed to market.</td>
<td>4.c</td>
<td>A.2.b, A.2.c, A.2.d, C.9.a, C.9.b, C.9.c</td>
</tr>
</tbody>
</table>
APPENDIX C – GLOSSARY OF TERMS

Adjusting Data – Adjusting data refers to any changes made when the modeler makes any to the raw data. For example, capping losses, on-leveling, binning, transformation of the data, etc. This includes scrubbing of the data.

Aggregated Data – Data summarized or compiled in a manner that is meaningful to the intended user of the data. Aggregation involves segmenting and combining individual data entries into categories based on common features within the data. For example, aggregated raw data requested for a predictive model would be categorized in the same manner as the categories of variables which receive specific treatments within the model outputs.

Big Data – “Big data” refers to extremely large datasets analyzed computationally to infer laws (regressions, nonlinear relationships, and causal effects) to reveal relationships and dependencies or to perform predictions of outcomes and behaviors.

Composite Characteristic – A composite characteristic is the combination of two or more individual risk characteristics. Composite characteristics are used to create composite variables. 

Composite Score – A composite score is a number derived by combining multiple variables by means of a sequence of mathematical steps; e.g., a credit-based insurance scoring model.

Composite Variable – A composite variable is a variable created by incorporating two or more individual risk characteristics of the insured into a single variable.

Continuous Variable – A continuous variable is a numeric variable that represents a measurement on a continuous scale. Examples include age, amount of insurance (in dollars), and population density.21

Control Variable – Control variables are variables whose relativities are not used in the final rating algorithm but are included when building the model. They are included in the model so that other correlated variables do not pick up their signal. For example, state and year are frequently included in countrywide models as control variables so that the different experiences and distributions between the states and across time do not influence the rating factors used in the final rating algorithm.22

Correlation Matrix – A correlation matrix is a table showing correlation coefficients between sets of variables. Each random variable (Xi) in the table is correlated with each of the other variables in the table (Xj). Using the correlation matrix, one can determine which pairs of variables have the highest correlation. Below is a sample correlation matrix showing correlation coefficients for combinations of five variables (B1:B5). The table shows that variables B2 and B4 have the highest correlation coefficient (0.96) in this example. The diagonal of the table is always set to one, because the correlation coefficient between a variable and itself is always 1. The upper-right triangle would be a mirror image of the lower-left triangle (because correlation between B1 and B2 is the same as between B2 and B1). In other words, a correlation matrix is also a symmetric matrix.23

Data Dredging – Data dredging is also referred to as data fishing, data snooping, data butchery, and p-hacking. It is the misuse of data analysis to find patterns in data that can be presented as statistically significant when, in fact, there is no real underlying effect. Data dredging is done by performing many statistical tests on the data and focusing only on those that produce significant results. Data dredging is in conflict with hypothesis testing, which entails performing at most a handful of tests to determine the validity of the hypothesis about an underlying effect.24


Data Mining – Data mining is a process used to extract usable data from a larger set of any raw data. It implies analyzing data patterns in large batches of data using one or more software programs. As an application of data mining, businesses can learn more about their customers and develop strategies related to various business functions. One application of data mining for insurance companies is analyzing large datasets to charge different groups of insureds different amounts of premium corresponding to their level of risk. Data mining involves substantial data collection and warehousing, as well as computer processing. For segmenting the data and evaluating the probability of future events, data mining uses sophisticated mathematical algorithms.  

Data Source – A data source is the original repository of the information used to build the model. For example, information from internal insurance data, an application, a vendor, credit bureaus, government websites, a sub-model, verbal information provided to agents, external sources, consumer information databases, etc.

Discrete Variable – A discrete variable is a variable that can only take on a countable number of values/categories. Examples include number of claims, marital status, and gender.

Discrete Variable Level – Discrete variables are generally referred to as “factors” (not to be confused with rating factors), with values that each factor can take being referred to as “levels.” For example, “one driver” and “more than one driver” may be levels within a “number of drivers” rating variable.

Double-Lift Chart – Double-lift charts are similar to simple quantile plots, but rather than sorting based on the predicted loss cost of each model, the double-lift chart sorts based on the ratio of the two models’ predicted loss costs. Double-lift charts directly compare the results of two models.

Exponential Family – The exponential family is a class of distributions that share the same general density form and have certain properties that are used in fitting GLMs. It includes many well-known distributions, such as the Normal, Poisson, Gamma, Tweedie, and Binomial, to name a few.

Fair Credit Reporting Act – The federal Fair Credit Reporting Act (FCRA), 15 U.S.C. § 1681 (FCRA) is U.S. federal government legislation enacted to promote the accuracy, fairness, and privacy of consumer information contained in the files of consumer reporting agencies. It was intended to protect consumers from the willful and/or negligent inclusion of inaccurate information in consumers’ credit reports. To that end, the FCRA regulates the collection, dissemination, and use of consumer information, including consumer credit information. Together with the federal Fair Debt Collection Practices Act (FDCPA), the FCRA forms the foundation of consumer rights law in the U.S. Originally enacted in 1970, the FCRA is enforced by the Federal Trade Commission, the Consumer Financial Protection Bureau, and private litigators.

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25 https://economictimes.indiatimes.com/definition/data-mining
Generalized Linear Model – Generalized linear models (GLMs) are a means of modeling the relationship between a variable whose outcome we wish to predict and one or more explanatory variables. The predicted variable is called the target variable and is denoted $y$. In property/casualty insurance ratemaking applications, the target variable is typically one of the following:

- Claim count (or claims per exposure).
- Claim severity (i.e., dollars of loss per claim or occurrence).
- Pure premium (i.e., dollars of loss per exposure).
- Loss ratio (i.e., dollars of loss per dollar of premium).

For quantitative target variables such as those above, the GLM will produce an estimate of the expected value of the outcome. For other applications, the target variable may be the occurrence or non-occurrence of a certain event. Examples include:

- Whether a policyholder will renew his/her policy.
- Whether a submitted claim contains fraud.

For such variables, a GLM can be applied to estimate the probability that the event will occur.

The explanatory variables, or predictors, are denoted $x_1 \ldots x_p$, where $p$ is the number of predictors in the model. Potential predictors are typically any policy term or policyholder characteristic that an insurer may wish to include in a rating plan. Some examples are:

- Type of vehicle, age, or marital status for personal auto insurance.
- Construction type, building age, or amount of insurance (AOI) for home insurance.\(^{30}\)

Geodemographic – Geodemographics is the study of the population and its characteristics, divided according to regions on a geographical basis. This involves application of clustering techniques to group statistically similar neighborhoods and areas with the assumption that the differences within any group should be less than the difference between groups. While the main source of data for a geodemographic study is U.S. Census Bureau data, the use of other sources of relevant data is also prevalent. Geodemographic segmentation is based on two principles:

1. People who live in the same neighborhood are more likely to have similar characteristics than are two people chosen at random.
2. Neighborhoods can be categorized in terms of the characteristics of the population that they contain. Any two neighborhoods can be placed in the same category; i.e., they contain similar types of people, even though they are widely separated.

Granularity of Data – Granularity of data is the level of segmentation at which the data is grouped or summarized. It reflects the level of detail used to slice and dice the data.\(^{31}\)

For example, a postal address can be recorded, with coarse granularity, as:

- Country

Or, with finer granularity, as multiple fields:

- Country
- State

Or, with much finer granularity, as multiple fields:

- Country
- State
- County
- ZIP code
- Property geo code


Home Insurance – Home insurance may cover, depending on the specific product, damage to the property, contents, and outstanding structures of a residential dwelling, as well as loss of use, liability, and medical coverage. The perils covered, the amount of insurance provided, and other policy characteristics are detailed in the policy contract. Common examples of home insurance policy forms are homeowners insurance (HO3 or HO5), renter’s insurance (HO4), and condominium insurance (HO6).

Insurance Data – Data collected by the insurance company directly from the consumer or through direct interactions with the consumer (e.g., claims). This is often referred to as “internal data.” For example, data obtained from the consumer through communications with an agent or on an insurance application would be “insurance data.” However, data obtained from a credit bureau or census would not be considered “insurance data” but would be considered “non-insurance data” instead.

Interaction Term – Two predictor variables are said to interact if the effect of one of the predictors on the target variable depends on the level of the other. Suppose that predictor variables \(X_1\) and \(X_2\) interact. A GLM modeler could account for this interaction by including an interaction term of the form \(X_1X_2\) in the formula for the linear predictor. For instance, rather than defining the linear predictor as \(\eta = \beta_0 + \beta_1X_1 + \beta_2X_2\), they could set \(\eta = \beta_0 + \beta_1X_1 + \beta_2X_2 + \beta_3X_1X_2\).

The following two plots of modeled personal auto bodily injury pure premium by age and gender illustrate this effect. The plots are based on two otherwise identical log-link GLMs, built using the same fictional dataset, with the only difference between the two being that the second model includes the age-gender interaction term, while the first does not. Notice that the male curve in the first plot is a constant multiple of the female curve, while in the second plot the ratios of the male to female values differ from age to age.

Lift Chart – See definition of “quantile plot.”

Linear Predictor – A linear predictor is the linear combination of explanatory variables \((X_1, X_2, \ldots, X_i)\) in the model; e.g., \(\beta_0 + \beta_1X_1 + \beta_2X_2\).

Link Function – The link function, \(\eta\) or \(g(\mu)\), specifies how the expected value of the response relates to the linear predictor of explanatory variables; e.g., \(\eta = g(E(Y_i)) = E(Y_i)\) for linear regression, or \(\eta = \text{logit}(\pi)\) for logistic regression.

Missing data – Missing data occurs when some records contain blanks or “Not Available” or “Null” where variable values would normally be available.

Non-Insurance Data – Non-insurance data is any data not defined as “insurance data.” Non-insurance data includes data provided by another party other than the insurance company and is often referred to as “external data.” For example, data obtained from a credit bureau or census would be considered “non-insurance data.” However, data obtained from the consumer through communications with an agent or on an insurance application would not be considered “non-insurance data” but would be “insurance data” instead.

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33 To see that this second definition accounts for the interaction, note that it is equivalent to \(\eta = \beta_0 + \beta_1X_1 + \beta_2X_2\) and to \(\eta = \beta_0 + \beta_1X_1 + \beta_2X_2\), with \(\beta_1' = \beta_1 + \beta_3X_2\) and \(\beta_2' = \beta_2 + \beta_3X_1\). Since \(\beta_1'\) is a function of \(X_2\) and \(\beta_2'\) is a function of \(X_1\), these two equivalences say that the effect of \(X_1\) depends on the level of \(X_2\) and vice versa.
35 https://online.stat.psu.edu/stat504/node/216.
Offset Variable – Offset variables (or factors) are model variables with a known or pre-specified coefficient. Their relativities are included in the model and the final rating algorithm, but they are generated from other studies outside the multivariate analysis and are fixed (not allowed to change) in the model when it is run. The model does not estimate any coefficients for the offset variables, and they are included in the model, so that the estimated coefficients for other variables in the model would be optimal in their presence. Examples of offset variables include limit and deductible relativities that are more appropriately derived via loss elimination analysis. The resulting relativities are then included in the multivariate model as offsets. Another example is using an offset factor to account for the exposure in the records; this does not get included in the final rating algorithm.36

Overfitting – Overfitting is the production of an analysis that corresponds too closely or exactly to a particular set of data and may, therefore, fail to fit additional data or predict future observations reliably.37

PCA Approach (Principal Component Analysis) – The PCA method creates multiple new variables from correlated groups of predictors. Those new variables exhibit little or no correlation between them, thereby making them potentially more useful in a GLM. A PCA in a filing can be described as “a GLM within a GLM.” One of the more common applications of PCA is geodemographic analysis, where many attributes are used to modify territorial differentials on, for example, a census block level.

Personal Automobile Insurance – Personal automobile insurance is insurance for privately owned motor vehicles and trailers for use on public roads not owned or used for commercial purposes. This includes personal auto combinations of private passenger auto, motorcycle, financial responsibility bonds, recreational vehicles and/or other personal auto. Policies include any combination of coverage such as the following: auto liability; personal injury protection (PIP); medical payments (MP); uninsured/underinsured motorist (UM/UIM); specified causes of loss; comprehensive; and collision.38

Post-Model Adjustment – Post-model adjustment is any adjustment made to the output of the model, including, but not limited to, adjusting rating factors or removal of variables.

Probability Distribution – A probability distribution is a statistical function that describes all the possible values and likelihoods that a random variable can take within a given range. The chosen probability distribution is supposed to best represent the likely outcomes.

Proxy Variable – A proxy variable is any variable that indirectly captures the characteristics of another variable, regardless of whether that other variable is used in the insurer’s rating plan.

38 https://content.naic.org/cipr_topics/topic_auto_insurance.htm.
Quantile Plot – A quantile plot is a visual representation of a model’s ability to accurately differentiate between the best and the worst risks. Data is sorted by predicted value from smallest to largest, and the data is then bucketed into quantiles with the same volume of exposures. Within each bucket, the average predicted value and the average actual value are calculated; and, for each quantile, the actual and predicted values are plotted. The first quantile contains the risks that the model predicts have the best experience and the last quantile contains the risks predicted to have the worst experience. The plot shows two things: 1) how well the model predicts actual values by quantile; and 2) the lift of the model (i.e., the difference between the first and last quantile), which is a reflection of the model’s ability to distinguish between the best and worst risks. By definition, the average predicted values would be monotonically increasing, but the average actual values may show reversals. An example follows:

![Quantile Plot Diagram]

Rating Algorithm – A rating algorithm is the mathematical or computational component of the rating plan used to calculate an insured’s premium.

Rating Category – A rating category is the same as a rating characteristic and can be quantitative or qualitative.

Rating Characteristic – A rating characteristic is a specific risk criterion of the insured used to define the level of the rating variable that applies to the insured; e.g., rating variable = driver age; rating characteristic = age 42.

Rating Factor – A rating factor is the numerical component included in the rate pages of the rating plan’s manual. Rating factors are used together with the rating algorithm to calculate the insured’s premium.

Rating Plan – The rating plan describes in detail how to combine the various components in the rules and rate pages to calculate the overall premium charged for any risk. The rating plan is specific and includes explicit instructions, such as:

- The order in which rating variables should be considered.
- How the effect of rating variables is applied in the calculation of premium (e.g., multiplicative, additive, or some unique mathematical expression).
- The existence of maximum and minimum premiums (or, in some cases, the maximum discount or surcharge that can be applied).
- Specifics associated with any rounding that takes place.

If the insurance product contains multiple coverages, then separate rating plans by coverage may apply.

Rating System – The rating system is the insurance company’s information technology (IT) infrastructure that produces the rates derived from the rating algorithm.

Rating Tier – A rating tier is rating based on a combination of rating characteristics rather than a single rating characteristic, resulting in a separation of groups of insureds into different rate levels within the same or separate companies. Often, rating tiers are used to differentiate quality of risk; e.g., substandard, standard, or preferred.

Rating Treatment – Rating treatment is the manner in which an aspect of the rating affects an insured’s premium.


Rating Variable – A rating variable is a risk criterion of the insured used to modify the base rate in a rating algorithm. A “rational explanation” refers to a plausible narrative connecting the variable and/or treatment in question with real-world circumstances or behaviors that contribute to the risk of insurance loss in a manner that is readily understandable to a consumer or other educated layperson. A “rational explanation” does not require strict proof of causality but should establish a sufficient degree of confidence that the variable and/or treatment selected are not obscure, irrelevant, or arbitrary.

A “rational explanation” can assist the regulator in explaining an approved rating treatment if challenged by a consumer, legislator, or the media. Furthermore, a “rational explanation” can increase the regulator’s confidence that a statistical correlation identified by the insurer is not spurious, temporary, or limited to the specific datasets analyzed by the insurer.

Raw Data – Data originating straight from the insurer’s data banks without modification (e.g., not scrubbed or transformed). Raw data may occur with or without aggregation. Aggregated raw datasets are those summarized or compiled prior to data selection and model building.

Sample Record – A sample record is one line of data from a data source including all variables. For example:

<table>
<thead>
<tr>
<th>Record</th>
<th>ZIP</th>
<th>CoverageType</th>
<th>Location</th>
<th>Age</th>
<th>Sex</th>
<th>Claims</th>
<th>LossIncurred</th>
<th>LossPaid</th>
<th>ClaimType</th>
<th>ClaimStatus</th>
<th>ClaimAmount</th>
<th>ClaimDate</th>
<th>ClaimId</th>
</tr>
</thead>
<tbody>
<tr>
<td>04254</td>
<td>25700</td>
<td>garage, basement</td>
<td>asphalt shingle</td>
<td>1680</td>
<td>213000</td>
<td>FORCED HOT WATER</td>
<td>1680</td>
<td>1</td>
<td>Ranch</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Scrubbed Data – Scrubbed data is data reviewed for errors, where “N/A” has been replaced with a value, and where most transformations have been performed. Data that has been “scrubbed” is now in a useable format to begin building the model.

Scrubbing Data – Scrubbing is the process of editing, amending, or removing data in a dataset that is incorrect, incomplete, improperly formatted, or duplicated.

SME – Subject-matter expert.

Sub-Model – A sub-model is any model that provides input into another model.

Variable Transformation – A variable transformation is a change to a variable by taking a function of that variable, for example, when age’s value is replaced by the value (age)^2. The result is called a transformation variable.

Voluntarily Reported Data – Voluntarily reported data is data directly obtained by a company from a consumer. Examples would be data taken directly from an application for insurance or obtained verbally by a company representative.

Univariate Model – A univariate model is a model that only has one independent variable.
APPENDIX D – SAMPLE RATE-DISRUPTION TEMPLATE

<table>
<thead>
<tr>
<th>State Division of insurance - EXAMPLE for Rate Disruption</th>
<th>Template Updated October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>• First, fill in the boxes for minimum and maximum individual impacts, shaded in light blue. Default values in the cells are examples only.</td>
<td></td>
</tr>
<tr>
<td>• The appropriate percent-change ranges will then be generated based on the maximum/minimum changes.</td>
<td></td>
</tr>
<tr>
<td>• For every box shaded in light green, replace &quot;ENTER VALUE&quot; with the number of affected insureds within the corresponding change range.</td>
<td></td>
</tr>
<tr>
<td>• Once all values are filled in, use the &quot;Charts&quot; feature in Excel to generate a histogram to visually display the spread of impacts.</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** Values of Minimum % Change, Maximum % Change, and Total Number of Insureds must reconcile to the Rate Rule Schedule in SERFF.

<table>
<thead>
<tr>
<th>Uncapped</th>
<th>Capped (If Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum % Change</td>
<td>-30.000%</td>
</tr>
<tr>
<td>Maximum % Change</td>
<td>30.000%</td>
</tr>
<tr>
<td>Total Number of Insureds (Auto-Calculated)</td>
<td>1994</td>
</tr>
</tbody>
</table>

### Uncapped Rate Disruption

<table>
<thead>
<tr>
<th>Percent-Change Range</th>
<th>Number of Insureds in Range</th>
<th>Percent-Change Range</th>
<th>Number of Insureds in Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>-30% to &lt; -25%</td>
<td>2</td>
<td>-15% to &lt; -10%</td>
<td>452</td>
</tr>
<tr>
<td>-25% to &lt; -20%</td>
<td>90</td>
<td>-10% to &lt; -5%</td>
<td>340</td>
</tr>
<tr>
<td>-20% to &lt; -15%</td>
<td>130</td>
<td>-5% to &lt; 0%</td>
<td>245</td>
</tr>
<tr>
<td>-15% to &lt; -10%</td>
<td>230</td>
<td>Exactly 0%</td>
<td>12</td>
</tr>
<tr>
<td>-10% to &lt; -5%</td>
<td>340</td>
<td>&gt;0% to &lt; 5%</td>
<td>150</td>
</tr>
<tr>
<td>-5% to &lt; 0%</td>
<td>245</td>
<td>5% to &lt; 10%</td>
<td>160</td>
</tr>
<tr>
<td>Exactly 0%</td>
<td>12</td>
<td>10% to &lt; 15%</td>
<td>401</td>
</tr>
<tr>
<td>&gt;0% to &lt; 5%</td>
<td>150</td>
<td>15% to &lt; 20%</td>
<td>234</td>
</tr>
<tr>
<td>5% to &lt; 10%</td>
<td>160</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10% to &lt; 15%</td>
<td>401</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15% to &lt; 20%</td>
<td>201</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20% to &lt; 25%</td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25% to &lt; 30%</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30% to &lt; 35%</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Capped Rate Disruption (If Applicable)

**EXAMPLE Uncapped Rate Disruption**

![Example Graph](ExampleGraph.png)

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EXAMPLE Capped Rate Disruption

-15% to < -10%  -10% to < -5%  -5% to < 0%  Exact  > 0% to < 5%  5% to < 10%  > 10% to < 15%  15% to < 20%

-15% to < -10%  -10% to < -5%  -5% to < 0%  Exact  > 0% to < 5%  5% to < 10%  > 10% to < 15%  15% to < 20%

Largest Percentage Increase | Corresponding Dollar Increase (for Insured Receiving Largest Percentage Increase)
--- | ---
Uncapped Change | 30.00% | Uncapped Dollar Change | $165.00 | Current Premium | $550.00
Capped Change (if Applicable) | 15.00% | Capped $ Change (if Applicable) | $82.50 | Proposed Premium | $632.50

Characteristics of Policy (Fill in Below)

- For Auto Insurance: At minimum, identify the age and gender of each named insured, limits by coverage, territory, make/model of vehicle(s), prior accident/violation history and any other key attributes whose treatments are affected by this filing.
- For Home Insurance: At minimum, identify age and gender of each named insured, amount of insurance, territory, construction type, protection class, any prior loss history, and any other key attributes whose treatments are affected by this filing.

Automobile policy: Three insureds - Male (Age 54), Female (Age 49), and Male (Age 25). Territory: Las Vegas, ZIP Code 89105.

<table>
<thead>
<tr>
<th>Vehicle</th>
<th>BI Limits:</th>
<th>PD Limits:</th>
<th>UM/UIM Limits:</th>
<th>MED Limits:</th>
<th>COMP Deductible:</th>
<th>COLL Deductible:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009 Ford Focus</td>
<td>$50,000 / $100,000</td>
<td>$25,000</td>
<td>$50,000 / $100,000</td>
<td>$5,000</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>2003 Honda Accord</td>
<td>$25,000 / $50,000</td>
<td>$10,000</td>
<td>$25,000 / $50,000</td>
<td>$1,000</td>
<td>$500</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

No prior accidents, 1 prior speeding conviction for 25-year-old male. Policy receives EFT discount and loyalty discount.

Primary impacts are the increases to the relativities for the age of insured, ZIP Code 89105, COLL Deductible of $1,000, and symbol for 2003 Honda Accord.

Most Significant Impacts to This Policy (Identify attributes—e.g., base-rate change or changes to individual rating variables)

- Insured Age (M/25): 12.00%  $66.00
- COLL Deductible ($1,000): 10.00%  $61.60
- Territory (89105): 4.00%  $27.30
- Vehicle Symbol (2003 Honda Accord): 1.46%  $10.29
- Effect of Capping: -11.54% - $82.50

TOTAL: 15.00%  $82.50

What lengths of policy terms does the insurer offer in this book of business?

[ ] 12-Month Policies
[ ] 6-Month Policies
[ ] 3-Month Policies
[ ] Other (SPECIFY)

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State Division of Insurance - EXAMPLE for Largest Dollar Increase

<table>
<thead>
<tr>
<th>Largest Dollar Increase</th>
<th>Corresponding Percentage Increase (for Insured Receiving Largest Dollar Increase)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncapped Change</td>
<td>$306.60 Current Premium $2,555.00 Uncapped Percent Change 12.00%</td>
</tr>
<tr>
<td>Capped Change (if Applicable)</td>
<td>$306.60 Proposed Premium $2,861.60 Capped % Change (if Applicable) 12.00%</td>
</tr>
</tbody>
</table>

Characteristics of Policy (Fill in Below)

- For Auto Insurance: At minimum, identify the age and gender of each named insured, limits by coverage, territory, make / model of vehicle(s), prior accident / violation history, and any other key attributes whose treatments are affected by this filing.
- For Home Insurance: At minimum, identify age and gender of each named insured, amount of insurance, territory, construction type, protection class, any prior loss history, and any other key attributes whose treatments are affected by this filing.

Automobile policy: Two insureds - Male (Age 33), Female (Age 32). Territory: Reno, ZIP Code 89504.

- 2016 Tesla Model S
  - BI Limits: $200,000 / $50,000
  - PD Limits: $200,000 / $50,000
  - UM/UIM Limits: $20,000 / $50,000
  - MED Limits: $10,000
  - COMP Deductible: $2,500
  - COLL Deductible: $2,500

- 2015 Mercedes-Benz C-Class (W205)
  - BI Limits: $200,000 / $50,000
  - PD Limits: $200,000 / $50,000
  - UM/UIM Limits: $20,000 / $50,000
  - MED Limits: $10,000
  - COMP Deductible: $2,500
  - COLL Deductible: $2,500

1 prior-at-fault accident for 32-year-old female. Policy receives EFT discount and loyalty discount.

Primary impacts are the increases to the relativities for the age of insured, symbol for 2015 Mercedes-Benz C-Class, and increased-limit factors for Property Damage and Medical Payments coverages.

Most Significant Impacts to This Policy (Identify attributes - e.g., base-rate change or changes to individual rating variables)

<table>
<thead>
<tr>
<th>Attribute</th>
<th>% Impact (Uncapped)</th>
<th>Dollar Impact (Uncapped)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured Age (M/33)</td>
<td>3.15%</td>
<td>$80.48</td>
</tr>
<tr>
<td>Insured Age (F/32)</td>
<td>3.23%</td>
<td>$85.13</td>
</tr>
<tr>
<td>Vehicle Symbol (2015 Mercedes-Benz C-Class)</td>
<td>2.45%</td>
<td>$66.65</td>
</tr>
<tr>
<td>Increased-Limit Factor for PD</td>
<td>1.55%</td>
<td>$43.20</td>
</tr>
<tr>
<td>Increased-Limit Factor for MED</td>
<td>1.10%</td>
<td>$31.14</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12.00%</td>
<td>$306.60</td>
</tr>
</tbody>
</table>

NOTE: If capping is proposed to apply for this policy, include the impact of capping at the end, after displaying uncapped impacts by attribute. Add rows as needed. Total percent and dollar impacts should reconcile to the values presented above in this exhibit.
PROJECT HISTORY

REGULATORY REVIEW OF PREDICTIVE MODELS

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

The Regulatory Review of Predictive Models white paper: 1) describes best practices for regulatory review of generalized linear models (GLMs), which is the most often filed model, for the private auto and home lines of business; and 2) provides changes to the Product Filing Review Handbook to include best practices for review of predictive models and analytics filed by insurers to justify rates.

In addition to the best practices, there is detail attached to the paper as Appendix B labeled as general and specific information elements that could be useful to a state insurance regulator when reviewing a rating plan based on a GLM. Additionally, there is commentary on what might be important about that information and some insight as to when the information might identify an issue the state insurance regulator needs to be aware of or explore further.

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

The white paper was drafted by the Casualty Actuarial and Statistical (C) Task Force. The volunteer drafters were: Rich Piazza, Chair, (LA); Vanessa Darrah and Tom Zuppan (AZ); Sydney Sloan (CO); Sue Andrews, Wanchin Chou and George Bradner (CT); Sandra Darby (ME); Phil Vigliaturo (MN); Gennady Stolyarov (NV); Eric Hintikka (TX); and Rosemary Raszka (VT). Daniel Davis (AL) and Gordon Hay (NE) participated in the first stages of drafting.

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

At the request of the Big Data (EX) Working Group, on June 27, 2018, the Property and Casualty Insurance (C) Committee charged the Casualty Actuarial and Statistical (C) Task Force with the following:

1. Draft and propose changes to the Product Filing Review Handbook to include best practices for review of predictive models and analytics filed by insurers to justify rates.
2. Draft and propose state guidance (e.g., information, data) for rate filings based on complex predictive models.

The white paper was adopted by the Casualty Actuarial and Statistical (C) Task Force on Sept. 15, 2020, and by the Property and Casualty Insurance (C) Committee on Dec. 8, 2020.

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

As directed by the Big Data (EX) Working Group, the Casualty Actuarial and Statistical (C) Task Force used the following principles in development of the white paper: 1) there should be no change to rate regulatory authority and autonomy of each individual state; 2) while maintaining such authority and autonomy, the states will share information and expertise and will discuss technical issues with each other; and 3) confidentiality in accordance with state laws should be maintained.

State insurance regulators drafted each version of the white paper, considered interest party comments and documented responses to each comment so all parties understood the reason for or against making changes to the paper. Interested parties provided rankings of the information elements, which were used along with the drafting group’s scores to arrive at the final rankings.

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

The Task Force exposed a first draft of the white paper in December 2018 for a 60-day public comment period. That exposure period was agreed to be extended an additional week. The second draft was exposed on May 14, 2019, for a 45-day public comment period. Additional sections of the paper were drafted to propose changes to the Product Filing Review Handbook and
add a short section on some proposed state guidance. On Aug. 3, 2019, these sections were released for a 45-day public comment period. On Oct. 15, 2019, the third draft of the white paper was exposed for a 38-day public comment period. On Aug. 5, 2020, the white paper was exposed for a 45-day public comment period. On Sept. 15, 2020, the Task Force adopted the final version.

The paper was discussed in almost every meeting throughout the period, and interested parties were allowed to provide oral comment in addition to written comment letters. The Task Force drafting group provided written comments on each of the interested party comments, so all were aware of the decision for or against making changes and why.

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

The following are some key issues identified during the white paper’s development:

1) Scope—The scope of the paper was narrowed to GLM models for personal auto and home lines of business. There are other types of models, but the GLM is the most often used type of model. The lines of business were selected because those are the ones where models are most often used. The Task Force noted that much of the guidance could be extracted as applicable for other models and lines of business.

2) Disparate impact and proxies for protected classes—The issue posed was that the white paper did not address these topics thoroughly. The Task Force agreed that the subject of disparate impact is beyond the scope of the white paper, given that it is not current law. Proxies for protected classes is mentioned in the white paper but was also identified as an “other consideration” in the white paper. With the NAIC Special (EX) Committee on Race and Insurance, these subjects would be further discussed after completion of the white paper.

3) Causation vs. correlation and “rational explanation”—An item in the list of “other considerations” is the issue of causality vs. correlation when evaluating a rating variable’s relationship to risk. The white paper does not recommend a requirement to prove causality; however, some state insurance regulators already expect justification beyond strict correlation. Many variables might be correlated, but that does not necessarily mean that the particular variable should be used in rating property/casualty (P/C) insurance. Therefore, the white paper suggests that companies should be prepared to provide a rational explanation for why a variable should be used in rating. If such an explanation cannot be provided, greater regulatory scrutiny of the variable may be appropriate. Further guidance on this subject is left as an “other consideration” of the white paper.

4) State confidentiality laws and/or regulations—Confidentiality continues to be an issue, but the drafting group believes it is addressed sufficiently. The white paper does not change the requirement for state insurance regulators to abide by state confidentiality laws and/or regulations. Anyone, including consultants and NAIC reviewers, involved in the regulatory review of rates is held to contract provisions that require abidance with state laws.

5) Overly prescriptive—Interested parties said the white paper is overly prescriptive, burdensome and results in costly rate regulation. At the advice of the NAIC Legal Division, a paragraph was added to the introduction that summarily says this white paper is for guidance only and has no direct impact on any state unless the state chooses to use the guidance. Additionally, the list of information elements included in the white paper were graded from 1–4, with 1 being most important to be filed. Industry participated in the scoring surveys.

6) Actuarial Standards of Practice (ASOPs)—There was a request for the inclusion of ASOPs in the white paper. Given the white paper applies to any filing, whether from an actuary or not, the Task Force did not add a discussion of ASOPs to the white paper. The Task Force believed actuaries should be aware that they have to abide by their own professional standards. The white paper deals with the filing itself and whoever is trying to support the filing.
7. **Key Provisions of the Model (sections considered most essential to state adoption)**

N/A

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

N/A
ANTIFRAUD PLAN GUIDELINE

Narrative

As insurance fraud costs insurers and consumers billions of dollars annually, and no line of insurance is immune to fraud, state departments of insurance (DOIs) believe it’s imperative that insurers make the detection, investigation and reporting of suspected fraud a priority in its overall operations. Failure to dedicate resources towards the fight against insurance fraud can tremendously affect an insurer’s financial stability, as well as rates charged to consumers. In light of the aforementioned, insurers are encouraged to proactively take measures to minimize the cost of fraud.

To encourage insurers to take a proactive approach to fighting fraud, and minimize organizational risk, many states require the preparation and/or submission of an antifraud plan. Such plans are often audited and inspected for compliance purposes and/or are reviewed in conjunction with market conduct and financial examinations conducted.

While the development and submission of an antifraud plan is currently not mandated in all states, most state DOIs and fraud fighting agencies believe it is a best practice for all insurers, whether state mandated or not, to develop an antifraud plan that which documents the antifraud efforts an insurer has put in place to prevent, detect investigate and report fraud. As such, this guideline is intended to serve as a guide for insurance company special investigation units (SIU) and other interested parties in the preparation of antifraud plans that meet state mandates.

In the spirit of promoting uniformity amongst the states, and providing insurers with added insight regarding key elements that should be considered when developing an antifraud plan, state fraud bureaus are encouraged to utilize this guideline to introduce new antifraud plan legislation or revise existing antifraud plan laws in their states.

To further uniformity in this area, and assist both insurers and state DOIs with compliance efforts, the NAIC Antifraud Task Force intends to utilize this revised guideline as a basis for developing an antifraud plan submission repository / system that will streamline insurer antifraud plan compliance nationwide. Until such a system is developed and implemented, insurers are encouraged to utilize this guideline, and incorporate all information outlined within the document when developing and/or updating company antifraud plans.

Important Note: Unless this guideline is adopted by a state, this guideline does not preempt existing state laws.
ANTIFRAUD PLAN GUIDELINE

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Section 1. Application
Section 2. Definitions [reserved]
Section 3. Antifraud Plan Creation/Submission Requirement
Section 4. Antifraud Plan Requirements
Section 5. 18 USC 1033 & 1034 Compliance
Section 6. Regulatory Compliance
Section 7. Confidentiality of Antifraud Plan
Section 8. Required Antifraud Plan Submission

Section 1. Application

The purpose of this guideline/regulation is to establish standards for state fraud bureaus, insurance company special investigation units (SIU) and any other interested parties regarding the preparation of an Antifraud Plan that meets the mandated requirements for submitting a plan with a state Department of Insurance. Currently, twenty states require that fraud plans be prepared for inspection by the state Departments of Insurance. The concept of mandating the submission of an insurer fraud plan was developed to encourage those insurers with direct written premiums to fight insurance fraud proactively by drafting a plan to fight fraud. This plan, along with audits, inspections, or in conjunction with a market conduct examinations, ensures the insurer is following its submitted antifraud plan.

These guidelines are primarily intended for state fraud bureaus as a guide in the preparation of new antifraud plan legislation, revision of existing mandated antifraud plans and for insurer SIUs in the preparation of its antifraud plans. The intention of this guideline is to collate the current twenty states’ antifraud plan requirements into a guide for those states researching what should go into a plan. Most national fraud fighting agencies believe it is a good practice for all insurers, whether it is state mandated or not, to develop an internal insurance antifraud plan. Flexibility should be allowed for each insurer to develop a plan that meets its individual needs and still meets state compliance standards.

This guideline does not preempt other state laws. This guideline is not intended to preempt or amend any guidance previously published by the NAIC Antifraud Task Force or in the NAIC Fraud Prevention Law Model Act. This document is intended to provide a road map for state fraud bureaus, insurers’ SIUs or contracted SIU vendors for preparation of an antifraud plan.

Drafting Note: In lieu of an agency name, states may amend this statement to incorporate a reference to a state law / rule.

Section 2. Definitions reserved for state-specific information

A. “Insurance” means any of the lines of authority authorized by state law.
B. “Insurance commissioner” or “commissioner” means the insurance commissioner of this state.
C. “Insurer” means a company required to be licensed under the laws of this state to provide insurance products.
D. “Material or substantive change” means any change, modification or alteration of the operations, standards, methods, staffing or outsourcing utilized by the insurer to detect, investigate and report suspected insurance fraud.
E. “National Association of Insurance Commissioners” (NAIC) means the organization of state insurance regulators from the fifty (50) states, the District of Columbia and all participating U.S. territories.
F. “Report in a timely manner” means in accordance with all applicable laws and rules of the state.

Drafting Note: States are able to insert a reference to a state law / rule if they feel it is necessary.
G. “Respond in a reasonable time” means to respond in accordance with all applicable laws and rules of the state.

**Drafting Note:** States are able to insert a reference to a state law / rule if they feel it is necessary.

H. “Special Investigation Unit” (SIU) means an insurer’s unit or division that is established to investigate suspected insurance fraud. The SIU may be made up of insurer employees or by contracting with other entities.

I. "Suspected Insurance Fraud” means any misrepresentation of fact or omission of fact pertaining to a transaction of insurance including claims, premium and application fraud. These facts may include but are not limited to evidence of doctoring, altering or destroying forms, prior history of the claimant, policy holder, applicant or provider, receipts, estimates, explanations of benefits (EOB), medical evaluations or billings, medical provider notes, police and/or investigative reports, relevant discrepancies in written or oral statements and examinations under oath (EUO), unusual policy activity and falsified or untruthful application for insurance. An identifiable pattern in a claim history may also suggest the possibility of suspected fraudulent claims activity. A claim may contain evidence of suspected insurance fraud regardless of the payment status.

**Drafting Note:** States can insert, modify or delete definitions as needed and/or insert references to state law if necessary.

Section 3. Antifraud Plan Creation/Submission Requirement

A. An insurer, if required by a Department of Insurance, subject to [insert appropriate state code], shall submit to the Commissioner [or Fraud Bureau] a detailed description of the company’s create an antifraud plan. All that documents the insurer’s antifraud efforts plans submitted shall be subject to review by the Commissioner.

B. An insurer shall develop a written plan within [insert number of days based upon state law] days after obtaining its license to transact business within this state or within [insert number of days] days after beginning to engage in the business of insurance.

C. The DOI has the right to review an insurer’s antifraud plan in order to determine compliance with appropriate state laws.

D. An insurer shall submit their antifraud plan in accordance with all state laws, regulations and requirements.

**Drafting Note:** States are able to insert a reference to a state law / rule if they feel it is necessary.

E. If an insurer makes a material / substantive change in the manner in which they detect, investigate and/or report suspected insurance fraud, or there is a change in the person(s) responsible for the insurer’s antifraud efforts, the insurer will be required to amend [and submit] their antifraud plan within [insert number of days] days of the change(s) being made.

**Drafting Note:** States without mandatory submission requirements should adjust this section appropriately.

Section 4. Antifraud Plan Requirements

A. The following information should be included in the submitted An antifraud plan to satisfy this Section. The plan is an acknowledgment that the insurer and its SIU has established criteria that will be used to overview of the insurer’s efforts to prevent, detect suspicious or fraudulent investigate and report all aspects of suspected insurance activity relating fraud related to the different types of insurance offered by that insurer. All antifraud plans submitted shall be subject to review by the Commissioner.

B. One SIU antifraud plan may cover several insurer entities if one SIU has the fraud investigation mission for all entities.
The plan should include:

A. General Requirements

C. (1) The following information should be included in the submitted antifraud plan to satisfy this Section:

(1) The insurer’s name and NAIC individual and group code numbers;
   (a) A description of the insurer’s approved lines of authority.

Drafting Note: Upon exploring the creation of an electronic fraud plan submission system, the working group will explore the possibility of the above noted information auto-populating based upon NAIC carrier data maintained by individual / group codes.

(2) An acknowledgment that the insurer has established criteria that will be used for the investigation of acts of internal fraud and suspected insurance fraud relating to the different types of insurance offered by that insurer.

(2) An acknowledgement that the insurer or SIU shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud were sent directly to the Fraud Bureau/Department within a specific time frame.

(3) A provision stating whether the SIU is an internal unit or an external or third party unit.

(3) A statement as to whether the insurer has implemented an internal and/or external fraud awareness and/or outreach program in order to educate employees, applicants, policy holders and/or members of the general public about insurance fraud.
   (a) A description of the insurer’s external fraud awareness or outreach program(s) geared towards applicants, policy holders and members of the general public.
   (b) A description of the insurer’s internal awareness / antifraud education and training initiatives of any personnel involved in antifraud related efforts. The description shall include:
      (i) An overview of antifraud training provided to new employees.
      (ii) The internal positions the insurer offers regular education and training to, such as underwriters, adjusters, claims representatives, appointed agents, attorneys, etc.
      (iii) A description of training topics covered with employees.
      (iv) The method(s) in which training is provided.
      (v) The frequency and minimum number of training hours provided.
      (vi) The method(s) in which employees, policyholders and members of the general public can report suspected fraud.

(4) A description of the insurer’s corporate policies for preventing, detecting and investigating suspected internal fraud committed by company employees, consultants or others, such as underwriters, claims representatives, appointed agents, etc.
   (a) The insurer shall include a description of their internal fraud reporting policy.
(b) The insurer shall identify the person and/or position within the organization who is ultimately responsible for the investigation of internal fraud.

(c) A description of the insurer’s standard operating procedures (SOP) for investigating internal fraud.

(d) The insurer shall include a description of the reporting procedures it will follow upon a criminal and/or insurance law violation being identified as the result of an internal investigation conducted (i.e. agent misconduct, referral to Fraud Unit or law enforcement, etc.).

(45) If the SIU is an internal unit, provide a description of whether the unit is part of the insurer’s claims or underwriting departments, or whether it is separate from such departments. A description of the insurer’s corporate policies for preventing fraudulent insurance acts committed by first- or third-party claimants, medical or service providers, attorneys, or any other party associated with a claim.

(a) A description of the technology and/or detection procedures the insurer has put in place to identify suspected fraud.

(b) The criteria used to report suspicious claims of insurance fraud for investigation to an insurer’s SIU.

(5) A written description or chart outlining the organizational arrangement of the insurer’s antifraud positions responsible for the investigation and reporting of possible fraudulent insurance acts.

(a) If SIU is an internal unit, the insurer shall provide general contact information for the company’s SIU.

(b) If SIU is an external unit, the insurer shall provide (1) the name of the company or companies used; (2) contact information for the company; and (3) a company organizational chart. The insurer shall specify the person or position at the insurer responsible for maintaining contact with the external SIU Company.

(c) If an external SIU is employed for purposes of surveillance, the insurer shall include a description of the policies and procedures implemented.

(6) A provision where the insurer provides the NAIC individual and group code numbers;

(6) A statement as to whether the insurer has established an internal SIU to investigate suspected insurance fraud.

(a) A description as to whether the unit is part of any other department within the organization.

(b) A description or chart outlining the organizational arrangement of all internal SIU positions/job titles.

(i) A general overview of each SIU position is required. In lieu of a general overview, insurers can provide a copy of all applicable position descriptions to the DOI.

Drafting Note: Upon exploring the creation of an electronic fraud plan submission system, the working group will explore the possibility insurers having the ability to upload an organization chart/list of SIU employees/position descriptions, etc.

(c) General contact information for the company’s SIU as well as contact information for the person/position(s) responsible for overseeing the insurer’s antifraud efforts.
(d) A description of the insurer’s SOPs for investigating suspected insurance fraud.

(7) A statement as to whether the insurer has implemented a fraud awareness or outreach program. If insurer has an awareness or outreach program, a brief description of the program shall be included;

(8) If the SIU is a third party unit, a description of the insurer’s policies and procedures for ensuring that the third party unit fulfills its contractual obligations to the insurer and a copy of the contract with the third party vendor.

(7) A statement as to whether the insurer utilizes an external/third party as their SIU or in conjunction with their internal SIU.

(a) If an external/third party is used to substantially perform the insurer’s SIU function, the insurer shall provide the name of the company(ies) used and contact information for the company(ies).

(b) The insurance shall specific the internal persons or position responsible for maintaining contact with the external company(ies) which will serve as the insurer’s SIU. The insurer shall provide a description how they will monitor and/or gauge the external/third party’s compliance with insurer antifraud mandates.

Drafting Note: If a state requires the disclosure of specific and/or all vendors for investigative activities conducted, this section can be modified accordingly.

(8) A description of the method(s) used to document SIU referrals received and investigations conducted.

(a) An overview of any case management system and/or computer program used to memorialize SIU referrals received and investigations conducted.

(b) The manner in which the insurer tracks SIU/investigative information for compliance purposes; i.e., the number of SIU referrals received, the number of investigations opened, the outcome of investigations conducted, etc.

Drafting Note: States that do not mandate fraud reporting should revise or remove inapplicable or have other requirements from should revise this section to reflect state requirements.

B. Prevention, Detection and Investigation of Fraud

(1) A description of the insurer’s corporate policies for preventing fraudulent insurance acts by its policy holders.

(2) A description of the insurer’s established fraud detection procedures (I.E. technology and other detection procedures).

(3) A description of the internal referral criteria used in reporting suspicious claims of insurance fraud for investigation by SIU.

(4) A description of SIU investigation program (I.E. by business line, external form claims adjustment, vendor management SOPs).

(5) A description of the insurer's policies and procedures for referring suspicious or fraudulent activity from the claims or underwriting departments to the SIU.

C. Reporting of Fraud
(1) A description of the insurer’s reporting procedures for the mandatory reporting of possible fraudulent insurance acts to the Commissioner/Bureau/Division pursuant to Section [Insert applicable State code].

(2) A description of the insurer’s criteria or threshold for reporting fraud to the Commissioner.

(3) A description of insurer’s means of submission of suspected fraud reports to the Commissioner (e.g. NAIC OFRS, NICB, NHCAA, electronic state system, or other).

(9) A description of the procedures the insurer has established to ensure that suspected insurance fraud is timely reported to [agency/division name] pursuant to [insert reference to state law].

   (a) A statement as to which individual(s) or group, within the organization is responsible for reporting suspected fraud on the insurer’s behalf.

   (i) When composing such a statement, companies may cite specific position descriptions in lieu of employee names.

   (ii) A description of the insurer’s criteria or threshold for reporting fraud to the Commissioner.

   (iii) A description of insurer’s means of submission of suspected fraud reports to the Commissioner (e.g. Online Fraud Reporting System (OFRS), National Insurance Crime Bureau (NICB), National Health Care Anti-Fraud Association (NHCAA), electronic state system, or other).

Drafting Note: States that do not mandate fraud reporting should revise or remove inapplicable requirements from this section.

Drafting Note: If a state has a mandatory reporting method, this section should be adjusted to reflect an acknowledgment of the reporting method.

D. Education and Training

(1) If applicable, a description of the insurer’s plan for antifraud education and training initiatives of any personnel involved in antifraud related efforts. This description shall include:

   (a) The internal positions the insurer offers regular education and training, such as underwriters, adjusters, claims representatives, appointment agents, attorneys, etc.

   (b) If the training will be internal and/or external.

   (c) Number of hours expected per year.

   (d) If training includes ethics, false claims or other legal-related issues.

E. Internal Fraud Detection and Prevention

(1) A description of insurer’s internal fraud detection policy for employees, consultants or others, such as underwriters, claims representatives, appointed agents, etc.

(2) A description of insurer’s internal fraud reporting system.

(10) An insurer shall incorporate within its antifraud plan the steps it will take to ensure all information they, or a contracted party possess with regard to a specific claim or incident of suspected insurance fraud is provided in a timely and complete manner when a formal written request from the [insert agency/division name] has been received.
Drafting Note: States who have a specific time period in which carriers must provide information can determine if a reference to a state statute or rule is warranted.

(b) Unless an insurer is able to cite legal grounds for withholding information, they must notredact or withhold any information that has been requested by the DOI.

(i) If an insurer has a reasonable belief that information cannot legally be provided to the DOI, the insurer will be required to provide, in writing, a description of any information being withheld, and cite the legal grounds for withholding such information.

Section 5. 18 USC 1033 & 1034 Compliance

The insurer shall include a description of its policies and procedures for candidates for employment and existing employees for compliance with 18 USC 1033 & 1034 [insert applicable State code if appropriate].

Section 65. Regulatory Compliance

A Department of Insurance has the right to review insurer antifraud plans in order to determine compliance with appropriate state laws. A Department further has the right, in accordance with Section [insert specific state code], to take appropriate administrative action against an insurer if it fails to comply with the mandated requirements and/or state laws.

Section 76. Confidentiality of Antifraud Plan

The submission of required information is not intended to constitute a waiver of an insurer’s privilege, trade secret, confidentiality or any proprietary interest in its antifraud plan or its antifraud related policies and procedures. The Commissioner shall maintain the antifraud plan as confidential. Submitted plans shall not be subject to the Freedom of Information Act (FOIA) if submitted properly under the state statutes or regulations which would afford protection of these materials [insert applicable state code].

Drafting Note: State will need to cite state specific privacy and protection authority.

Section 8. Required Antifraud Plan Submission

An insurer, if required by a Department of Insurance, shall submit its antifraud plan within ninety days of receiving a certificate of authority. Plans shall be submitted every 5 years thereafter. An insurer shall submit revisions to its plans within thirty days of a material change being made.

Drafting Note: States without mandatory submission requirements should adjust this section appropriately.
Project History

ANTIFRAUD PLAN GUIDELINE

1. Description of the Project, Issues Addressed, etc.
   In 2020, the Antifraud (D) Task Force discussed implementation of the revised Antifraud Plan Guideline (#1690). Currently, 23 states require their insurers to file an Antifraud Plan with their insurance commissioner. The purpose of an Antifraud Plan is to describe in detail how the company detects, addresses and prevents insurance fraud.

2. Name of Group Responsible for Drafting the Model and States Participating
   The Antifraud Technology (D) Working Group of the Antifraud (D) Task Force.
   Chair: Utah. Participating states: Arizona, Arkansas, California, Florida, Louisiana, New Mexico, Ohio, Texas and Virginia.

3. Project Authorized by What Charge and Date First Given to the Group
   On Dec. 10, 2019, the Antifraud Technology (D) Working Group was given the charge to “[r]each and provide recommendations for the development of an Antifraud Plan Repository to be used by insurers to centrally file their antifraud plan to all states/jurisdictions.” The revision of Guideline #1690 was determined to be the first step in completing this charge. The Working Group continues to discuss potential recommendations for an Antifraud Plan Repository.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.
   The Antifraud Technology (D) Working Group initially sent a request for comments on Nov. 25, 2019, to the Antifraud (D) Task Force, interested state insurance regulators, and interested parties. The Working Group chair and the Ohio Working Group member drafted the initial revisions to Guideline #1690 that was exposed for comment in March 2020.

   The Working Group met again Sept. 17, 2020, to discuss additional comments received and review proposed revisions. The Working Group exposed a second draft for comment following the September call.

   The Working Group met Oct. 14, 2020, to review the final draft and Oct. 29, 2020, to adopt the revised Guideline #1690.

   Working Group members, state insurance regulators, and interested parties provided comments, and they were invited to participate in all Working Group calls. Revised drafts were released for comment following each Working Group call. The drafts were circulated via email and posted to the Task Force web page on the NAIC home page.

   Written comments were received by the following groups:

   Interested State Insurance Regulators

   Minnesota, Ohio and Utah.
Interested Parties
The Center for Economic Justice (CEJ), the Coalition Against Insurance Fraud (CAIF), the National Association of Mutual Insurance Companies (NAMIC), and the National Insurance Crime Bureau (NICB).

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

The initial draft of Guideline #1690 was exposed in December 2019. Comments were received until Dec. 31, 2019. The Antifraud Technology (D) Working Group met in March 2020 to discuss the comments received.

A second draft was distributed following the call in March. Due to the COVID-19 pandemic, the activity of the Working Group was temporarily delayed, and the comment period was extended until September. The Working Group met in September and October to finalize and adopt the revisions to Guideline #1690.

In October 2020, the Antifraud (D) Task Force exposed the revised draft for comment. No comments were received on the revised draft. The Task Force met Nov. 16, 2020, to discuss the proposed revisions and adopt the revised Guideline #1690.

The Market Regulation and Consumer Affairs (D) Committee adopted the revised Guideline #1690 during the 2020 Fall National Meeting.

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

The purpose of Guideline #1690 is to bring greater uniformity among the states in antifraud plan requirements and to be used as a template in creating the Antifraud Plan Repository. This Antifraud Plan Repository is intended to streamline the process used by industry to submit their Antifraud Plans to all appropriate insurance departments and streamline the process for state review.

Ohio suggested incorporating a comprehensive narrative at the beginning of Guideline #1690 to explain its purpose as a best practice because not all states mandate the reporting of Antifraud Plans. Antifraud Technology (D) Working Group members, state insurance regulators, and industry representatives unanimously agreed that the language suggested by Ohio was not necessary. The Working Group decided to reorganize the structure of the existing Guideline #1690 and keep the existing language.

The Working Group added and changed definitions within Guideline #1690. The Antifraud (D) Task Force decided to modify these changes by using certain definitions from existing NAIC model laws.

The first definition added was “insurance commissioner” or “commissioner.” The Working Group incorporated the definition used in the Insurance Data Security Model Law (#668).

The next definition added was for “insurer.” In the initial draft, the Working Group defined “insurer” as a business entity who is in the process of obtaining or has obtained a certificate of authority to enter into arrangements of contracts of insurance or reinsurance and who agrees to: 1) pay or indemnify another as to loss from certain contingencies called “risks,” including through reinsurance; 2) pay or grant a specified amount or determinable benefit to another in connection with ascertainable risk contingencies; 3) pay an annuity to another; or 4) act as surety. Except for using the language “including annuities,” the Task Force decided to use language found in the Suitability in Annuity Transactions Model Regulation (#275) definition for “insurer.” This language states that an “insurer is a company required to be licensed under the laws of this state to provide insurance products, including annuities.”

The last definition added was for the “NAIC” stating, “the NAIC is the organization of insurance regulators from 50 states, the District of Columbia and all participating U.S. territories.”
The Task Force members, state insurance regulators, and interested parties unanimously agreed that Guideline #1690 should not be considered a regulation but rather a guideline to assist states that currently require the submission of an Antifraud Plan and encourage the remaining jurisdictions to adopt a requirement for insurers’ submission of an Antifraud Plan.

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

None.

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GUIDELINE FOR ADMINISTRATION OF LARGE DEDUCTIBLE POLICIES IN RECEIVERSHIP

Drafting Note: Having the necessary statutory authority specific to large deductible workers’ compensation products in receiverships is key to the successful resolution of these insurers. There are currently two statutory authority options available, and there are differences across states as to which authority has been adopted: 1) Section 712 of the NAIC Insurer Receivership Model Act (#555—IRMA), Administration of Loss Reimbursement Policies; and 2) the National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Legislation, Administration of Large Deductible Policies and Insured Large Deductible Collateral. Both provide statutory guidance that articulates the respective rights and responsibilities of the various parties, which greatly enhance a state’s ability to manage complex large deductible programs in liquidation. Generally, both approaches provide for the collection of reimbursements, resolve disputes over who gets the reimbursements and ensure that the claimants are paid. The provisions in each of the two options generally complement each other, except for conflicting provisions regarding the issue of the ultimate ownership of, and entitlement to, the deductible recoveries and large deductible collateral as between the estate and the guaranty association. The issue is whether the guaranty associations, on behalf of the claimants, are entitled to any deductible reimbursements or whether they are a general estate asset that is shared pro rata by the guaranty associations and the uncovered claimants.

As of the drafting of this Guideline, the NCIGF model approach has been adopted by several states using varying language. However, the NCIGF model has evolved over time based on additional experiences from insolvencies and the NCIGF continues to modify its model as warranted. The NAIC has developed the following Guideline based largely on the principles and structure of the NCIGF model with certain modifications made by the NAIC Large Deductible Workers’ Compensation (E) Working Group of the Receivership and Insolvency (E) Task Force. The following statutory language is not an amendment to the NAIC receivership models but is intended as a Guideline for use by states as an alternative to IRMA Section 712, Administration of Loss Reimbursement Policies.

Administration of Large Deductible Policies in Receivership

This Guideline shall apply to workers’ compensation large deductible policies issued by an insurer subject to delinquency proceedings under [insert cite to state’s receivership statute]. Large deductible policies shall be administered in accordance with their terms, except to the extent such terms conflict with this Guideline. This Guideline does not apply to policies where the insurer has no liability for the portion of a claim that is within the deductible or self-insured retention.

A. Definitions.

For purposes of this Guideline:

(1) “Large deductible policy” means any combination of one or more workers’ compensation policies and endorsements and contracts or security agreements entered into between an insurer and the insurer in which the insured has agreed with the insurer to:

(a) Pay directly the initial portion of any claim covered under the policy up to a specified dollar amount which the insurer would otherwise be obligated to pay, or the expenses related to any claim; or

(b) Reimburse the insurer for its payment of any claim or related expenses under the policy up to the specified dollar amount of the deductible.

The term “large deductible policy” includes policies which contain an aggregate limit on the insured’s liability for all deductible claims, a per-claim deductible limit or both. The primary purpose and distinguishing characteristic of a large deductible policy is the shifting of a portion of the ultimate financial responsibility under the large deductible policy to pay claims from the insurer to the insured, even though the obligation to initially pay claims may remain with the insurer, and the insurer remains liable to claimants in the event the insured fails to fulfill its payment or reimbursement obligations.

Drafting Note: States may wish to establish a minimum dollar deductible threshold for application of this statute based on local conditions. Because the payment of the entire amount of the claim remains the unconditional obligation of the insurer, the insured’s loss reimbursement obligation should not be treated as a “deductible” for the purpose of any applicable exclusion from guaranty association coverage, even though these policies are commonly referred to as “large deductible policies.”

Large deductible policies do not include policies, endorsements or agreements which provide that the initial portion of any covered claim shall be self-insured and further that the insurer shall have no payment obligation within the self-insured retention. Large deductible policies also do not include policies that provide for retrospectively rated premium payments by the insured or reinsurance arrangements or agreements,

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except to the extent such reinsurance arrangements or agreements are put in place as security for the policyholder’s large deductible obligations.

(2) “Deductible claim” means any allowed claim, including a claim for loss and defense and cost containment expense (unless such expenses are excluded), under a large deductible policy to the extent it is within the deductible.

(3) “Large deductible collateral” means any cash, letters of credit, surety bond, or any other form of security posted by the insured, or by a captive insurer or reinsurer, to secure the insured’s obligation under the large deductible policy to pay deductible claims or to reimburse the insurer for deductible claim payments. Large deductible collateral may also secure an insured’s obligation to reimburse or pay to the insurer as may be required for other secured obligations.

(4) “Commercially reasonable” means to act in good faith using prevailing industry practices and making all reasonable efforts considering the facts and circumstances of the matter.

(5) “Other secured obligations” means obligations of an insured to an insurer other than those under a large deductible policy, such as those under a reinsurance agreement or other agreement involving retrospective premium obligations the performance of which is secured by large deductible collateral that also secures an insured’s obligations under a large deductible policy.

B. Handling of Large Deductible Claims.

Unless otherwise agreed by the responsible guaranty association, all large deductible claims that are also “covered claims” as defined by the applicable guaranty association law, including those that may have been funded by an insured before liquidation, shall be turned over to the guaranty association for handling.

(1) If a deductible claim is not covered by any guaranty association, the receiver shall draw on available large deductible collateral to pay the claim; or make other arrangements with the insured to ensure the timely payment of the claim. The receiver shall pay the claim promptly from the large deductible collateral unless the insured pays the claim directly or there is no available large deductible collateral.

(2) Deductible claims paid by the insured or by the receiver in accordance with this Guideline shall not be treated as distributions of estate assets under [insert cite to state’s liquidation priority distribution statute]. To the extent the insured, or a third-party administrator on behalf of the insured, pays the deductible claim, pursuant to an agreement by the guaranty association or otherwise, the insured’s payment of a deductible claim in whole or in part will extinguish the obligations, if any, of the receiver and/or any guaranty association to pay that claim or that portion of the claim. No credit or charge for an imputed or constructive distribution of any kind shall be made against the receiver or a guaranty association on the basis of an insured’s payment of a deductible claim.

Drafting Note: This provision addresses so called “orphan claims,” which are situations where, because of variations in state law or for other reasons, claims generally covered by the guaranty fund system are not provided such protection. States should take steps, through statutory revision or otherwise, to avoid orphan claims, especially for workers’ compensation insurance. However, if such claims do exist, this provision permits the receiver to utilize available large deductible collateral, or other funds provided by the employer, to ensure that they continue to be paid. Alternative language that states may consider is as follows: “In cases where a deductible claim is not a guaranty association covered claim and the claimant has no other remedy either from the employer or other resources available in a state, the receiver may pay the claim to the extent of the deductible with available Large deductible collateral as described in subsection E(2) below.”

C. Deductible Claims Paid by a Guaranty Association.

To the extent a guaranty association pays any deductible claim for which the insurer would have been entitled to reimbursement from the insured, a guaranty association shall be entitled to the amount of the reimbursement, and available large deductible collateral as provided for under subsection E to the extent necessary to reimburse the guaranty association. Such amounts shall be paid to the guaranty association net of any of the receiver’s collection costs as described in subsection F. Reimbursements paid to the guaranty association pursuant to this subsection shall not be treated as distributions under [insert cite to state’s liquidation priority distribution statute] or as early access payments under [insert cite to state’s early access statute].
To the extent that a guaranty association pays a deductible claim that is not reimbursed either from large deductible collateral or by an insured’s payments, or incurs expenses in connection with large deductible policies that are not reimbursed under this subsection, the guaranty association shall be entitled to assert a claim for those amounts in the delinquency proceeding, except as provided in subsection D(5).

Nothing in this subsection limits any rights of the receiver or a guaranty association that may otherwise exist under applicable law to obtain reimbursement from insureds for claims payments made by the guaranty association under policies of the insurer or for the guaranty association's related expenses, such as those provided for pursuant to [insert cite to state’s guaranty association net worth provision], or existing under similar laws of other states.

D. Collections

(1) The receiver shall take all commercially reasonable action to ensure that the large deductible collateral remains adequate to secure the insured’s obligations, and to collect reimbursements owed for deductible claims as provided for herein:

(a) Paid by the insurer prior to the commencement of delinquency proceedings;

(b) Paid by a guaranty association upon receipt by the receiver of notice from a guaranty association of reimbursable payments;

(c) Paid or allowed by the receiver; or

(d) Approved by the receiver for payment.

(2) If the insured does not make payment within the time specified in the large deductible policy, or within sixty (60) days after the date of billing if no time is specified, the receiver shall take all commercially reasonable actions to collect any reimbursements owed.

(3) Neither the insolvency of the insurer, nor the receiver’s or insurer’s inability to perform any of its obligations under the large deductible policy, shall be a defense to the insured’s reimbursement obligation under the large deductible policy.

(4) An allegation of improper handling or payment of a deductible claim by the insurer, the receiver and/or any guaranty association shall not be a defense to the insured’s reimbursement obligations under the large deductible policy.

(5) If the receiver declines to seek or is unsuccessful in obtaining reimbursement from the insured for a large deductible obligation and there is no available large deductible collateral, a guaranty association may, after notice to the receiver, seek to collect the reimbursement due from the insured on the same basis as the receiver, and with the same rights and remedies including without limitation the right to recover reasonable costs of collection from the insured. The guaranty association shall report any amounts so collected from each insured to the receiver. The receiver shall provide the guaranty association with available information needed to collect a reimbursement due from the insured. The receiver shall notify all other guaranty associations that have paid large deductible claims on behalf of the same insured. Amounts collected by a guaranty association pursuant to this paragraph shall be treated in accordance with subsection C. The expenses incurred by a guaranty association in pursuing reimbursement shall not be permitted as a claim in the delinquency proceeding at any priority, except as agreed by the receiver at or before the time the expenses are incurred; however, a guaranty association may net the expenses incurred in collecting any reimbursement against that reimbursement.

E. Large Deductible Collateral

(1) Subject to the provisions of this subsection, the receiver shall utilize large deductible collateral, when available, to secure the insured’s obligation to fund or reimburse deductible claims or other secured obligations or other payment obligations. A guaranty association shall be entitled to large deductible collateral as provided for in this subsection to the extent needed to reimburse a guaranty association for the payment of a deductible claim. Any payments made to a guaranty association pursuant to this subsection...
shall not be treated as distributions of estate assets under [Insert cite to state’s liquidation priority distribution statute] or as early access payments under [Insert cite to state’s early access statute]. Such payments shall extinguish the receiver’s obligations to the guaranty association with respect to any claim or portion of a claim that has been reimbursed from large deductible collateral.

(2) All claims against the large deductible collateral shall be paid first to reimburse claim payments made by the insurer, the receiver, or the guaranty associations to reimburse their deductible claim payments on large deductible policies. After these obligations are satisfied, remaining claims shall be paid in the order received and no claim of the receiver, except in accordance with this subsection, shall supersede any other claim against the large deductible collateral.

(3) Notwithstanding any agreement between the insured and the insurer, the receiver shall draw down large deductible collateral to the extent necessary in the event that the insured fails to:

(a) Perform its funding or payment obligations under any large deductible policy;
(b) Pay deductible claim reimbursements within the time specified in the large deductible policy or within sixty (60) days after the date of the billing if no time is specified;
(c) Pay amounts due the estate for pre-liquidation obligations;
(d) Timely fund any other secured obligation; or
(e) Timely pay expenses.

(4) Excess large deductible collateral may be returned to the insured when deemed appropriate by the receiver after a periodic review of claims paid, outstanding case reserves, and allowance for adverse development and claims incurred but not reported as determined by the receiver.”

F. Administrative Fees

(1) The receiver is entitled to recover through billings to the insured or from large deductible collateral all reasonable expenses that the receiver incurred in fulfilling its collection obligations under this Guideline. All such deductions or charges shall be in addition to the insured’s obligation to reimburse claims and related expenses and shall not diminish the rights of claimants or guaranty associations.

(2) To the extent the receiver cannot collect such expenses pursuant to paragraph (1), the receiver is entitled to deduct from the large deductible collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the large deductible collateral and deductible reimbursements.

(3) To the extent such amounts are not available from reimbursements or large deductible collateral, the receiver, or guaranty associations if provided under an agreement with the receiver under subsection D(5), shall have a claim against the estate as provided pursuant to [insert cite to state’s liquidation priority distribution statute].

Drafting Note: State policymakers should decide whether this provision, when enacted, should apply to existing liquidations.
State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

Life Insurance and Annuities (A) Committee

- Amendments to the *Suitability in Annuity Transactions Model Regulation (#275)*—These revisions were adopted by the Executive (EX) Committee and Plenary during the February 13, 2020 conference call. Seven states have enacted these revisions to the model.

- Amendments to the *Standard Nonforfeiture Law for Individual Deferred Annuities (#805)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

Health Insurance and Managed Care (B) Committee

- Amendments to the *Accident and Sickness Insurance Minimum Standards Model Act (#170)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2019 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the *Health Maintenance Organization Model Act (#430)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the *Insurance Holding Company System Regulatory Act (#440)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Adoption of the *Limited Long-Term Care Insurance Model Act (#642)*—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Adoption of the *Limited Long-Term Care Insurance Model Regulation (#643)*—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

Property and Casualty Insurance (C) Committee

- Adoption of the *Travel Insurance Model Act (#632)*—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. Six states have enacted this model.

Financial Condition (E) Committee

- Amendments to the *Life and Health Insurance Guaranty Association Model Act (#520)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2017 Fall National Meeting. 34 states have enacted these revisions to the model.
• Amendments to the *Credit for Reinsurance Model Law (#785)*—These revisions were adopted by the Executive (EX) Committee and Plenary during the June 26, 2019 conference call. 18 states have enacted this model.

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

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The Executive (EX) Committee met April 14, 2021. The following Committee members participated: David Altmaier, Chair (FL); Dean L. Cameron, Vice Chair (ID); Chlora Lindley-Myers, Vice President (MO); Andrew N. Mais, Secretary-Treasurer (CT); Raymond G. Farmer, Most Recent Past President (SC); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Michael Conway (CO); Doug Ommen (IA); James J. Donelon (LA); Kathleen A. Birrane (MD); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); and Larry D. Deiter (SD). Also participating were: Vicki Schmidt (KS); Sharon P. Clark (KY); and Elizabeth Kelleher Dwyer (RI).

1. Adopted the April 7 Report of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee

Commissioner Altmaier reported the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee met April 7 in joint session. The meeting was held in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings.

During this meeting, the Committee and Subcommittee took the following action: 1) adopted its March 16, 2021; Feb. 24, 2021; and 2020 Fall National Meeting minutes, which included the following action: a) approved the March 3 Internal Administration (EX) Subcommittee minutes, including investment reports and recommendation on the NAIC’s long-term investment portfolio; and b) approved next steps for the Long-Term Care Insurance (LTCI) Legal Restructuring fiscal, which includes: i) deferral of action by the Executive (EX) Committee until further deliberation can be completed; ii) appointment of the Long-Term Care Insurance Restructuring (E) Subgroup of the Restructuring Mechanisms (E) Working Group and its proposed charge; and iii) recommendation by the Subgroup to be provided to the Committee and Subcommittee by September 2021; c) approved the exposure of the System for Electronic Rate and Form Filing (SERFF) Modernization – Mobilization and Pilot Phase fiscal for public comment; d) approved the exposure of the State Based System (SBS) State Implementations 2021 fiscal for public comment; e) approved the exposure of the property/casualty (P/C) rate Model Review Staffing Resources fiscal for public comment; f) appointed a member to the National Insurance Producer Registry (NIPR) Board of Directors; g) ratified moving the Financial Stability (EX) Task Force to report to the Financial Condition (E) Committee; h) appointed non-regulator members to the SERFF Advisory Board; i) appointed members to the Consumer Participation Board of Trustees; j) approved an amendment to the NAIC Grant and Zone Fund Policy; and k) selected Las Vegas, NV, for the 2025 Fall National Meeting.

The Committee and Subcommittee adopted the report of the Audit Committee, which met April 1 and took the following action: 1) received an overview of the Dec. 31, 2020, financial statements, with an update for Feb. 28, 2021; 2) received the 2020 audit report from RSM; and 3) received an update on the 2020/2021 Service Organization Control (SOC) 1 and SOC 2 reviews.

The Committee and Subcommittee also adopted the report of the Information Systems (EX1) Task Force, which met March 24 and took the following action: 1) adopted its 2020 Fall National Meeting minutes; 2) received an update on the 2021 SERFF fiscal; and 3) received an operational report on the NAIC’s information technology (IT) activities.

The Committee and Subcommittee: 1) approved the exposure of the Solvency Workpaper Software Modernization – Implementation Preparation Phase fiscal; 2) approved the SERFF Modernization – Mobilization and Pilot Phase fiscal; 3) approved the SBS State Implementations 2021 fiscal; 4) approved the P/C Rate Model Review Staffing Resources fiscal; 5) received a joint chief executive officer (CEO)/chief operating officer (COO) report; and 6) discussed the development of the State Ahead 2.0 strategic plan.

Commissioner Conway made a motion, seconded by Director Wing-Heier, to adopt the April 7 report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee. The motion passed.

2. Adopted its March 16 and Feb. 24 Interim Meeting Report

Commissioner Mais made a motion, seconded by Director Cameron, to adopt the Committee’s March 16 and Feb. 24 interim meeting report (Attachment One). The motion passed.
3. **Adopted the Reports of its Task Forces**

The Committee received reports from: the Climate and Resiliency (EX) Task Force; the Government Relations (EX) Leadership Council; the Innovation and Technology (EX) Task Force; the Long-Term Care Insurance (EX) Task Force; and the Special (EX) Committee on Race and Insurance.

Commissioner Altmaier reported that the Long-Term Care Insurance (EX) Task Force conducted an e-vote to consider adoption of the 2021 proposed charges for the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup. The Subgroup will continue discussions that began in 2020 on specific issues related to reduced benefit options (RBOs) and to provide support and expertise to the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup.

Director Farmer made a motion, seconded by Commissioner Altman, to adopt the reports of: the Climate and Resiliency (EX) Task Force; the Government Relations (EX) Leadership Council; the Innovation and Technology (EX) Task Force; the Long-Term Care Insurance (EX) Task Force, including the charges for the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup; and the Special (EX) Committee on Race and Insurance (Attachment Two). The motion passed.

4. **Adopted a Request for NAIC Model Law Development Regarding Model #870**

Commissioner Schmidt reported that during the Dec. 8 meeting of the Property and Casualty Insurance (C) Committee, the Request for NAIC Model Law Development regarding the [Nonadmitted Insurance Model Act](#870) was discussed and approved by the Committee. Model #870 has been in place since 1994 and was last updated in 2002. Currently, 31 states have adopted the model. The federal Nonadmitted and Reinsurance Reform Act (NRRA) of 2010 addresses the following areas not currently included in Model #870: 1) the application of “Home State” provision for purposes of jurisdictional authority and paying premium tax; 2) licensure requirements for brokers; 3) diligent search requirements; and 4) eligibility requirements for nonadmitted insurers.

Commissioner Schmidt also reported that the proposed amendments to Model #870 would encompass not only updates to bring the model in alignment with the NRRA, but also would modernize the model. The work will be completed within one year.

Commissioner Donelon made a motion, seconded by Commissioner Birrane, to adopt the Request for NAIC Model Law Development to develop amendments to Model #870 (Attachment Three). The motion passed.

5. **Received the 2020 Annual Report of NAIC Designation Program Advisory Board Activities**

Commissioner Clark provided an update on the NAIC Designation Program Advisory Board’s activities and the 2020 achievements for the NAIC Insurance Regulator Professional Designation Program (Attachment Four). In 2020, there was an increase of more than 300 insurance regulator designation enrollments. At year-end, enrollment totaled 2,687 since its inception in 2006. State insurance regulators have earned 1,500 professional insurance regulation designations.

Commissioner Clark noted that the Advisory Board met virtually monthly in 2020 to discuss policy recommendations, renewal credits, and the future of the program and how to best promote awareness and support.

Commissioner Clark also reported that the Advisory Board completed some notable accomplishments in 2020, entering into a contract with Certemy to replace the existing enrollment site with Certemy’s program management system. The new enrollment site went live on March 23, 2021.

Commissioner Clark also reported that several changes to the program requested by members included: 1) waiving the first test retake fee; 2) removing tenure requirements for the Associate Professional in Insurance Regulation (APIR) and Professional in Insurance Regulation (PIR) designations; and 3) allowing courses to be taken “out of sequence.”

Commissioner Clark encouraged members to make additional recommendations that would enhance the program for use by the states. She said suggestions can be made to your state mentor, your zone representative to the Advisory Board, or the NAIC Education and Training Department. The State Mentor program provides a liaison between each state department and the NAIC’s Education and Training Department to help disseminate information and assist with candidates’ questions. The State Mentor list is on the Designation Program’s web page.

Commissioner Clark thanked the previous board chair, Superintendent Dwyer, for her hard work and dedication to the program.
6. Received a Status Report on the NAIC State Ahead Strategic Plan Implementation

Commissioner Altmaier provided an update on NAIC State Ahead implementation efforts. State Ahead is a three-year strategic plan for the organization intended to further advance the products, services and support the NAIC provides to state insurance regulators in order to better meet the changing regulatory landscape. NAIC staff continue to make good progress on the many State Ahead projects. Attachment Five contains the highlights of the State Ahead implementation at the operational level, as well as highlights in the NAIC 2020 Annual Report. In 2020, the NAIC paused on the development of State Ahead 2.0 to focus on COVID-19. The membership has now started the conversation on development of the next iteration of State Ahead.

7. Received a Report of Model Law Development Efforts

Commissioner Altmaier presented a written report on the progress of ongoing model law development efforts (Attachment Six).

8. Heard a Report from the NIPR Board of Directors

Director Deiter reported the NIPR Board of Directors had a busy and productive 2020. In 2020, NIPR processed 38 million credentialing and report transactions, a year-over-year increase of 5.2%. Despite the pandemic, NIPR earned $47.9 million in revenue, representing a 5.7% increase from 2019. NIPR also submitted $969 million in fees from NIPR to state departments of insurance (DOIs), which is a 14% increase over 2019. Visit www.NIPR.com to review the 2020 Annual Report.

The NIPR Board of Directors recently approved the 2021–2023 NIPR Strategic Plan – Our Bridge to the Future. NIPR’s new strategic plan sets the vision and guides its growth for the next three years and into the future. The strategic plan reflects NIPR’s success and lessons learned, which will enable NIPR to thrive and grow in a post-pandemic environment. The plan has three areas of focus or pillars, each with distinctive goals that are connected to NIPR’s values of teamwork, excellence, trust and innovation. The three pillars are: 1) Engaged and Empowered Team; 2) Customer-Focused Excellence; and 3) High-Quality and Reliable Technology. The strategic plan is posted at www.nipr.com.

Already this year, NIPR has been working to bring more products and services to state and industry customers. NIPR is excited to announce that contact change requests for business entities are available online through NIPR. The new capability enables business entities to utilize NIPR’s online product and eliminates the need for a separate state by state notification process for updating the entity’s contact information. Arizona, Nebraska, North Carolina, North Dakota and Rhode Island are live in production. NIPR plans a phased state rollout plan, and as other states are ready to go live, a separate state notification will be posted.

NIPR is also launching a chat feature for its customer call center to enhance the channels available to answer questions for the “walk-up” industry customers. Finally, NIPR has been busy working with California and Hawaii to implement adjuster licensing online through NIPR.

9. Heard a Report from the Compact

Superintendent Dwyer reported that the Interstate Insurance Product Regulation Commission (Compact) met March 23 and heard a report from then Director Bruce R. Ramee (NE), chair of the Compact’s Audit Committee, that the Compact received an unqualified opinion from its independent auditor RSM.

The Compact also appointed Commissioner Birrane to serve as chair of the Audit Committee for the remainder of the year.

The Compact released its 2020 Annual Report, and all Compacting states are encouraged to review the Compact’s activities and financial results for 2020. The Compact is required to send a copy of the Annual Report to all its members, as well as governors and legislatures in the Compacting states.

The Compact had a successful financial year, ending with positive revenue of $77,000 and the completion of two key strategic plan action items: 1) the independent governance review; and 2) the independent business assessment. With respect to these projects, the Compact has created a Governance Committee. The Governance Committee is reviewing the recommendations for good governance, as well as the implied congressional consent analysis, which may address a key issue from last year’s Colorado Supreme Court opinion.
The key item of business during its March 23 meeting was to receive a recommendation from the Compact’s Product Standards Committee on whether and how the amendment to change the minimum nonforfeiture rate in Section 4 of the Standard Nonforfeiture Law for Individual Deferred Annuities (#805) from 1% to 0.15%, which was adopted by the NAIC Executive (EX) Committee and Plenary in December 2020, should become effective in the Uniform Standards. The provision, which is the subject of the amendment, is incorporated by reference in the Uniform Standards for deferred annuities.

By operation of the Uniform Standards, the NAIC-adopted amendment would have been immediately effective and would be allowed for Compact-approved products, even though the model would likely require legislative change to be effective in state law.

In December 2020, the Compact issued its first-ever emergency rule to stay the effectiveness of the Model #805 amendment in the Uniform Standards and ask its Product Standards Committee to review and provide a recommendation back to the Compact.

During its March 23 meeting, the Product Standards Committee recommended amendments to the Uniform Standards to change the minimum nonforfeiture rate to follow state law. The proposed changes to the Uniform Standards must go through the rulemaking process, which requires notice, comment and a public hearing, and upon adoption, a 90-day period before such changes would be implemented.

The Compact also adopted its second emergency rule, which replaces the first emergency rule and adopts the proposed amendments being recommended by the Product Standards Committee for a period of 180 days. The emergency rule and the proposed amendments will require companies to follow the state law with respect to the minimum nonforfeiture rate, so it will allow companies to use the lower rate only if allowed by state law.

The Compact received other recommendations from its Product Standards Committee, including Guidelines for Uniform Standards Development, which would include a new system for annual identification and prioritization for Uniform Standards development. The Compact is also considering amendments to three draft Uniform Standards for waiver benefits.

Having no further business, the Executive (EX) Committee adjourned.
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

EXECUTIVE (EX) COMMITTEE
March 16, 2021 / February 24, 2021

Summary Report

The Executive (EX) Committee met March 16 and Feb. 24, 2021, in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During these meetings, the Committee:

1. Adopted the Internal Administration (EX1) Subcommittee’s March 3 minutes, including investment reports and recommendations on the NAIC’s long-term investment portfolio.

2. Approved the next steps for the Long-Term Care Insurance (LTCI) Legal Restructuring Fiscal.

3. Approved the exposure of the System for Electronic Rate and Form Filing (SERFF) Modernization – Mobilization and Pilot Phase Fiscal for public comment.

4. Approved the State Based Systems (SBS) State Implementations 2021 Fiscal for public comment.

5. Approved the exposure of the Property/Casualty (P/C) Rate Model Review Staffing Resources Fiscal for public comment.

6. Appointed Commissioner Sharon P. Clark (KY) to serve on the National Insurance Producer Registry (NIPR) Board of Directors, effective April 9, 2021.

7. Received an update on 2020 year-end financial results.

8. Reviewed the NAIC Conflict of Interest Policy.


10. Approved the following non-regulator appointments to the SERFF Advisory Board (SAB): Birny Birnbaum (Center for Economic Justice—CEJ) as the Consumer Representative; Andrea Davey (Athene Annuity and Life Company) for Life Insurance and Vice Chair; Phyllis Hollerbach (Zurich North America) for Health Insurance; and Susan Gould (The Hanover Insurance Group) for P/C.

11. Appointed the following members to the 2021 Consumer Board of Trustees: Commissioner Michael Conway (CO) as Chair; Director Chlora Lindley-Myers (MO); Superintendent Russell Toal (NM); Commissioner John F. King (GA); Commissioner Marlene Caride (NJ); and Commissioner Jessica K. Altman (PA).

12. Reappointed the following Consumer Representatives to serve on the Board for 2021: Amy Bach (United Policyholders); Brendan Bridgeland (Center for Insurance Research—CIR); Bonnie Burns (California Health Advocates); Brenda J. Cude (University of Georgia); Katie Keith, (Out2Enroll); and Sarah Lueck (Center on Budget and Policy Priorities).

13. Approved an amendment to the NAIC Grant and Zone Fund Policy.


15. Selected Las Vegas, NV for the 2025 Fall National Meeting.
REPORT OF THE EXECUTIVE (EX) COMMITTEE TASK FORCES

Climate and Resiliency (EX) Task Force—The Climate and Resiliency (EX) Task Force met April 9 and took the following action: 1) heard reports from its workstreams; 2) received a recommendation from the Climate Risk Disclosure Workstream; 3) heard a presentation regarding the building code and mitigation workshop; 4) heard an update on NAIC Communications activities; 5) heard an update on federal activities; and 6) heard an update on international activities. The Task Force also met Feb. 16 in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss strategic priorities related to climate risk and resiliency.

Government Relations (EX) Leadership Council—The Government Relations (EX) Leadership Council did not meet at the Spring National Meeting. The Leadership Council meets weekly in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss federal legislative and regulatory developments affecting insurance regulation.

Innovation and Technology (EX) Task Force—The Innovation and Technology (EX) Task Force met April 9 and took the following action: 1) adopted minutes from the 2020 Fall National Meeting and reports of the Big Data and Artificial Intelligence (EX) Working Group and the Speed to Market (EX) Working Group. The Task Force also heard a report from the April 1 Innovation and Technology State Contacts Roundtable; 2) discussed and made assignments regarding prioritizing and taking action related to issues identified based on the requests for information (RFIs) related to continuing specific “regulatory relief” or “regulatory accommodations” offered by states as a result of the COVID-19 pandemic. The Task Force members voted to appoint a Working Group to examine e-commerce laws and regulations; survey states regarding federal Uniform Electronic Transactions Act (UETA) exceptions; and work toward meaningful, unified recommendations. The working group will also examine whether a model bulletin would be appropriate for addressing some of the identified issues and will draft a proposed bulletin if determined appropriate. The Task Force also referred identified issues related to allowing online processes to be used for producer licensing continuing education (CE) to the Producer Licensing (D) Task Force; referred surplus lines issues to the Surplus Lines (C) Task Force since it falls within its current workstream to amend the Nonadmitted Insurance Model Act (#870); and discussed possibly drafting a model bulletin related to the same issue; 3) heard InsurTech presentations from State Farm and USAA, Trellis, and Vero; 4) discussed issues related to consumer data ownership; 5) received an update from the various groups working on related workstreams, including the Special (EX) Committee on Race and Insurance, the Accelerated Underwriting (A) Working Group, the Property and Casualty Insurance (C) Committee and the Privacy Protections (D) Working Group; 6) heard an update on the predictive model review process; and 7) discussed the Coded Bias event held on March 31 and a possible follow-up meeting.

The Big Data and Artificial Intelligence (EX) Working Group met March 29 and took the following action: 1) reviewed the work of the Big Data (EX) Working Group and the Artificial Intelligence (EX) Working Group and why these Working Groups were merged; 2) reviewed the Working Group’s 2021 charges; 3) discussed developing an industry survey to research how insurance companies are using big data, algorithms and artificial intelligence (AI) while protecting the confidentiality of individual company responses to a survey; and 4) heard a presentation to introduce the development and components of a model governance framework based on other models (e.g., capital, catastrophe) used to manage risk associated with the use of data that factor into important business decisions for insurers.

The Speed to Market (EX) Working Group met March 10 and took the following action: 1) adopted its Nov. 10, 2020, minutes; 2) heard an update from the Interstate Insurance Product Regulation Commission (Compact); 3) discussed the results of the Product Requirement Locator (PRL) survey and next steps. The System for Electronic Rate and Form Filing (SERFF) team will be reaching out to states based on the survey responses provided to gather additional information as needed to assist states using the PRL. It is unlikely that the PRL tool will be available beyond the completion of the SERFF modernization project, which is anticipated in the next couple of years, and more likely that the SERFF modernization project will include ways for states to provide their filing requirements within SERFF, making it easier for states to keep their requirements up to date and to satisfy the need for those requirements to be easily accessible to SERFF users; 4) received updates on SERFF, including recent and upcoming releases and projects. The request for proposal (RFP) for the SERFF modernization project is in the final stage for the mobilization and pilot. A press release announcing vendor selection and kick-off of the project will be released soon; and 5) discussed the annual review of the product coding matrix (PCM) and uniform transmittal document (UTD) suggestions. Proposed revisions or changes can be submitted at any time throughout the year, but for suggestions to be considered to go in effect for next year, the deadline is May 31.
Long-Term Care Insurance (EX) Task Force—The Long-Term Care Insurance (EX) Task Force met April 9 and took the following action: 1) adopted its March 1 and 2020 Fall National Meeting minutes, which included adoption of the 2021 proposed charges of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup (Attachment Two-A). The Subgroup charges include:

A. Further evaluate and/or recommend options to help consumers manage the impact of rate increases. This includes:
   1. The potential development of a process to evaluate innovative options that allow for insurers to offer benefits that lessen the likelihood of an insured needing long-term care (LTC) services, including the evaluation of the suitability of and regulatory barriers to proposed options.
   2. The potential development of mechanisms to help state insurance regulators and consumers objectively compare reduced benefit options (RBOs), including the comparison of accepting a rate increase and retaining current benefits to electing offered RBOs.
   3. The further exploration of pursuing more uniformity in consumer notices for RBOs.
B. Support and provide expertise to the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup regarding the evaluation of RBOs.
C. Complete its charges by the 2021 Summer National Meeting.

During its April 9 meeting, the Task Force also received the reports of its subgroups: 1) the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, which has drafted the operational section of a multistate rate review framework; 2) the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup, which plans to meet in May to begin addressing its charges; and 3) the Long-Term Care Insurance Financial Solvency (EX) Subgroup, which reported on industry trends and factors affecting reserve levels. The Task Force released the draft multistate rate review operational framework for a 45-day public comment period ending May 24.

Special (EX) Committee on Race and Insurance—The Special (EX) Committee on Race and Insurance met in regulator-to-regulator session on April 6 and March 24, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings and in open session on April 12. During its regulator-to-regulator sessions, the Special Committee took the following action: 1) received initial recommendations from its workstreams; 2) discussed where in the NAIC committee structure to place the necessary work to come; and 3) reviewed a set of proposed charges. The charges were exposed for a short public comment period. During its April 12 open meeting, the Special Committee took the following action: 1) heard reports from its five workstreams; and 2) heard comments from interested parties on the proposed charges. An additional exposure period ending May 14 was approved.

- Workstream One of Special Committee submitted an initial report to the Special (EX) Committee on Race and Insurance outlining its findings, as well as its recommendations to the Executive (EX) Committee and membership on next steps.
- Workstream Two of the Special Committee is directed at analyzing the level of diversity within the NAIC and the state insurance regulatory community. The workstream met Jan. 22 in regulator-to-regulator session. During that meeting, the NAIC presented its responses to a set of questions directed towards its efforts on diversity, equity and inclusion (DE&I). The workstream also discussed an information-gathering tool to examine, at the zone level, initiatives that state insurance departments can consider to promote DE&I in their offices.
- Workstream Three of the Special Committee is focused on property/casualty (P/C) insurance issues. The workstream has met four times to develop a list of issues that it wishes to focus on. The workstream leveraged the issues list to create a final report in January that it submitted to the Special Committee for its consideration. The report included potential charges related to affordability; availability and access; producer issues; education and outreach; and unfair discrimination.
- Workstream Four of the Special Committee met Nov. 16, 2020, and Oct. 30, 2020, in regulator-to-regulator session and Dec. 10, 2020, and Jan. 5, 2021, in open session. During its regulator-only meetings, the workstream discussed and prioritized issues. During its open meetings, it heard presentations from various stakeholders. The workstream drafted and adopted an initial report and recommendations via e-vote ending Feb. 5 and forwarded it to the Special Committee for its consideration.
- Workstream Five of the Special Committee held a member organization meeting Oct. 20, 2020. During this meeting, the workstream discussed its charge and reviewed its: 1) next steps and deliverables; 2) timeline; and 3) potential
issues for workstream focus related to health care disparities in health insurance access and affordability. The workstream held a stakeholder meeting Dec. 2, 2020, to discuss the potential issues identified. The workstream held additional regulator-to-regulator meetings following its Dec. 2, 2020, meeting to develop and finalize its initial report. The workstream finalized its report March 23 and has forwarded it to the Special Committee for its consideration.
Ongoing Support of NAIC Programs, Products or Services

1. The Long-Term Care Insurance (EX) Task Force will:
   A. Recognizing the gravity of the threat posed by the current long-term care insurance (LTCI) environment both to consumers and our state-based system of insurance regulation, this Task Force is charged to:
      1. Develop a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization.
      2. Further evaluate and recommend options to provide consumers with choices regarding modifications to LTCI contract benefits where policies are no longer affordable due to rate increases.
      3. Deliver such a proposal to the Executive (EX) Committee by the 2021 Summer National Meeting.

2. The Long-Term Care Insurance Multistate Rate Review (EX) Subgroup will:
   A. Develop a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. The Subgroup should complete its charges by the 2021 Summer National Meeting.

3. The Long-Term Care Insurance Financial Solvency (EX) Subgroup will:
   A. Explore restructuring options and techniques to address potential inequities between policyholders in different states and techniques to mitigate policyholders’ risk to state guaranty fund benefit limits, including states’ pre-rehabilitation planning options. Evaluate the work of the consultant and report on the work to the Task Force.
   B. Monitor work performed by other NAIC solvency working groups and assist in the timely multi-state coordination/communication of the review of the financial condition of long-term care (LTC) insurers.
   C. Complete its charges by the 2021 Summer National Meeting.

4. The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup will:
   A. Further evaluate and/or recommend options to help consumers manage the impact of rate increases. This includes:
      1. The potential development of a process to evaluate innovative options that allow for insurers to offer benefits that lessen the likelihood of an insured needing LTC services, including the evaluation of the suitability of and regulatory barriers to proposed options.
      2. The potential development of mechanisms to help state insurance regulators and consumers objectively compare reduced benefit options (RBOs), including the comparison of accepting a rate increase and retaining current benefits to electing offered RBOs.
      3. The further exploration of pursuing more uniformity in consumer notices for RBOs.
   B. Support and provide expertise to the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup regarding the evaluation of RBOs.
   C. Complete its charges by the 2021 Summer National Meeting.

NAIC Support Staff: Jeffrey C. Johnston

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REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

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

Surplus Lines (C) Task Force

2. NAIC staff support contact information:

Andy Daleo, Senior Financial Analysis Manager (adaleo@naic.org)
Dan Schelp, Chief Counsel, Regulatory Affairs (dschelp@naic.org)

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

Nonadmitted Insurance Model Act (#870) – See Attached

On August 5, 2020, the Surplus Lines (C) Task Force discussed revisions to Model #870, and directed NAIC staff to form an informal Drafting Group composed of regulators from Louisiana, Oklahoma and Washington to produce a summary document that outlines the significant updates to modernize Model #870 and present a recommendation to the Task Force at a future national meeting. The attached Model #870 contains the Drafting Group’s recommendations with respect to modification of Model #870 to both bring it into compliance with the Nonadmitted and Reinsurance Reform Act (NRRA) as well as other amendments to modernize the model.

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

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

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

If yes, please explain why

The Nonadmitted Insurance Model Act (#870) has been adopted in 31 states, with other states adopting older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. Every state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands have surplus lines guidance in place.

The NRRA was adopted July 21, 2011, and is contained within the Dodd-Frank Wall Street Reform and Consumer Protection Act (Act). The NRRA requirements and the mandate of the federal Act create uniformity for the collection of surplus lines tax payments through the implementation of the “Home State” requirement. All states comply with the NRRA’s home state tax approach.

Model 870 was not modified because of the implementation of the NRRA. However, on October 11, 2011, a Nonadmitted Insurance Reform Sample Bulletin (copy attached) was adopted by Executive/Plenary and
subsequently distributed to the state insurance departments. It is important to provide guidance for uniformity among the states in order to ensure compliance with the NRRA.

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

☑ Yes  ☐ No  (Check one)

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

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood  Low Likelihood

Explanation, if necessary: Due to the previous adoption of the Nonadmitted Insurance Reform Sample Bulletin by the NAIC, there is already uniformity of intent with respect to key areas addressed by the NRRA. The Surplus Lines (C) Task Force should be able to leverage that agreement to quickly and efficiently finish revisions to Model #870.

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

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood  Low Likelihood

Explanation, if necessary: Surplus Lines is an important industry in every state and U.S. Territory, and it is important to provide uniform guidance to the NAIC members to ensure compliance with the federal NRRA.

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

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood  Low Likelihood

Explanation, if necessary: Model #870 is not an accreditation requirement, but as previously stated it is important to provide uniform guidance to the states to ensure compliance with the NRRA.

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

No

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

Yes, the proposed revisions to Model #870 are in direct response to the federal NRRA, which would preempt inconsistent state law.
To: Members of the NAIC Executive Committee

From: Commissioner Sharon Clark, Kentucky Department of Insurance
Chair, NAIC Insurance Regulator Professional Designation Program Advisory Board

Date: April 14, 2021

Subject: 2020 Annual Report of NAIC Designation Program Advisory Board Activities

In October of 2006, the NAIC launched the Insurance Regulator Professional Designation Program (“Designation Program”), a formal credentialing program designed for regulators, by regulators to establish structured training and development paths for insurance department employees. In that same year, the Internal Administration (EX1) Subcommittee directed the program’s Advisory Board to present a brief annual report of program benchmarks and board activities. This memorandum, with its supplemental charts, sets forth an account of the program’s year in review.

Program Enrollments

We continued our outreach to states and have seen increased interest and enrollments across the board. In 2020, the NAIC Education & Training Department processed nearly 300 Designation Program enrollments, bringing the total number of enrollments since 2006 to 2,687.

We awarded 217 new designations in 2020. By year-end, earned designation totals were as follows: 1090 APIR designees, 386 PIR designees, 22 SPIR designees, and 2 IPIR designees.

The Designation Program Mentoring Network

States have been encouraged to appoint a “mentor” that can serve as a liaison between the Department and the NAIC’s Education & Training Department as a means of disseminating information about the program to interested regulators, and to assist candidates as they have questions. All but one territory has individuals active in this role. Most mentors have earned an NAIC Designation or are currently working toward one.

Designation Program Advisory Board Meetings

The Designation Program Advisory Board met monthly throughout 2020 via conference call to discuss policy matters and other issues. Discussion items included policy recommendations and promotion of the program to increase awareness and participation.

2020 Accomplishments

Several significant accomplishments occurred in 2020, including:

- Work to replace the program’s enrollment site with a new program management system (Certemy) to streamline and automate many of the processes done manually today, which will provide a better user experience for program participants. Work was completed with a soft rollout of the new system in February 2021, with a full rollout in late March 2021.
- Created and implemented a new course for the APIR level, “Introduction to Financial Regulation for Non-Financial Regulators.”
- Updated program policies in response to program participant needs and requests (waiving first retake fee, removing tenure requirements for APIR and PIR, and allowing courses to be taken “out of sequence”).
- Granted a 1-year extension on all Designation renewal dates.

**About the Insurance Regulator Professional Designation Program Advisory Board**

The 2020 Advisory Board was composed of Laura Arp (NE Department of Insurance), Rachel Chester (RI Insurance Division), Eric Fletcher (ID Department of Insurance) and Scott Sanders (GA Department of Insurance).

Rhode Island Superintendent Beth Dwyer chaired the 2020 Advisory Board.

In addition to overseeing Designation Program policy and advising NAIC Education Department staff on designation program policy administration, the board members work on outreach to regulators during NAIC Zone Meetings and other regulatory meetings. Additional information about the Designation Program can be found by visiting the NAIC website: [http://naic.org/education_designation.htm](http://naic.org/education_designation.htm)
## TOTAL ENROLLMENTS - 2687

### Designation Participation by Zone

As of December 31, 2020

<table>
<thead>
<tr>
<th>Western Zone</th>
<th>Enrollments</th>
<th>Southeastern Zone</th>
<th>Enrollments</th>
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Enrollments by Zone

- Western: 24%
- Southeastern: 20%
- Midwestern: 24%
- Northeastern: 32%
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<td><strong>1090 386 22 2</strong></td>
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</tr>
</tbody>
</table>
Model Law Development Report

Amendments to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)—Amendments to Model #171 are required for consistency with the federal Affordable Care Act (ACA). Therefore, they did not require approval of a Request for NAIC Model Law Development by the Executive (EX) Committee. At the 2015 Fall National Meeting, the Regulatory Framework (B) Task Force discussed the proposed revisions to this model. The Task Force met Feb. 11, 2016, and appointed the Accident and Sickness Insurance Minimum Standards (B) Subgroup to work on revisions to this model. The Subgroup has been meeting on a regular basis since the 2016 Spring National Meeting, and it plans to continue meeting until it completes its work. During its meetings, the Subgroup has discussed several issues, including its approach for revising the model’s disability income insurance coverage provisions, and it decided preliminarily to review the Interstate Insurance Product Regulation Commission’s (Compact’s) approach. After pausing its work due to the ACA’s potential repeal, replacement or modification—and the possible impact on the provisions of this model, as well as the Subgroup’s preliminary proposed revisions to the model—the Subgroup began meeting again in May 2018. Revisions to the Unfair Trade Practices Act Amendments to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#170) were adopted by the full NAIC membership at the 2019 Spring National Meeting. The Subgroup has been meeting to consider revisions to Model #171 for consistency with the revised Model #170 since the 2019 Summer National Meeting discussion on comments received on Sections 1–5 of Model #171. In December 2019, the Subgroup set a public comment period ending Feb. 7 to receive comments on Section 6 and Section 7 of Model #171. Due to the COVID-19 health emergency, the Subgroup has not scheduled any meetings. Any future meetings will depend on when a new co-chair is appointed and the duration of the COVID-19 health emergency. As requested, the Subgroup received comments from stakeholders on Section 6 and Section 7 of Model #171. A new Subgroup co-chair has been appointed. It is anticipated that the Subgroup will resume meeting sometime in late April or early May to: 1) complete its discussion of the comments received on Sections 1–5 of Model #171; and 2) begin discussion of the comments received on Section 6 and Section 7 of Model #171.

Amendments to the Annuity Disclosure Model Regulation (#245)—The Executive (EX) Committee met June 19, 2017, and approved a Request for NAIC Model Law Development to amend Model #245. The amendments will revise Section 6—Standards for Illustrations. The purpose of the revision is to address issues identified by the Annuity Disclosure (A) Working Group of the Life Insurance and Annuities (A) Committee related to innovations in annuity products that are not addressed, or not addressed adequately, in the current standards. Revisions addressing participating income annuities were adopted by the Life Insurance and Annuities (A) Committee during its July 19, 2018, meeting and held pending the resolution of the Working Group’s discussions regarding illustrating indexes in existence for less than 10 years. The Working Group continues to discuss additional revisions on the index issue. The Working Group made progress during discussions in late 2019 and early 2020, and it received an extension from the Life Insurance and Annuities (A) Committee at the 2020 Summer National Meeting to finish its work. The Working Group is currently awaiting additional direction from the Committee before resuming its work.

Amendments to the Life Insurance Disclosure Model Regulation (#580)—The Executive (EX) Committee met June 19, 2017, and approved a Request for NAIC Model Law Development to incorporate a policy overview document requirement into Model #580 and the Life Insurance Illustrations Model Regulation (#582) in order to improve the understandability of the life insurance policy summary and narrative summary already required by Section 5A(2) of Model #580 and Section 7B of Model #582. While the Life Insurance Illustration Issues (A) Working Group of the Life Insurance and Annuities (A) Committee was originally planning to revise both Model #580 and Model #582, it will now revise only Model #580. The Working Group has been meeting to develop language to add a requirement for a one- to two-page consumer-oriented policy overview. The Working Group continued to make progress during meetings in late 2019 and early 2020, and it received an extension from the Life Insurance and Annuities (A) Committee at the 2020 Summer National Meeting to continue its work. The Working Group met Feb. 23 and March 10 and is close to completing alternative draft versions of a sample policy overview document for term life policies. One version shows the sample pre-under writing, and the other shows the sample post-underwriting. The Working Group is developing these alternative versions to aid the Committee in providing guidance to the Working Group with respect to the timing of the delivery of the policy overview document.

Amendments to the Unfair Trade Practices Act (#880)—The Executive (EX) Committee approved a Request for NAIC Model Law Development to amend Model #880 at the 2019 Fall National Meeting. The Innovation and Technology (EX) Task Force drafted amendments to Model #880, focusing on Section 4H, to clarify what is considered a “rebate” or “inducement.” A drafting group was formed, led by Superintendent Elizabeth Kelleher Dwyer (RI), to develop language for exposure. The drafting group held its first meeting on Jan. 27, 2020, followed by three more meetings. Five drafts were discussed, and the drafting group disbanded on June 17, 2020. The draft coming out of that work was distributed and posted to the NAIC website.
for comment. The Innovation and Technology (EX) Task Force discussed the draft language during its meeting at the Summer National Meeting. Three more drafts, followed by comment periods, were published. During a meeting on Nov. 30, oral presentations were made by various commenters on the draft dated Oct. 30. Based on comments submitted Nov. 18 and during the Nov. 30 meeting, an updated draft was published on Dec. 2. The Task Force adopted the draft during its meeting on Dec. 4, and the Executive (EX) Committee adopted it on Dec. 9. The revised model will be considered by Executive (EX) Committee and Plenary on April 14, 2021.

**Amendments to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)**—The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #440 and Model #450 at the 2020 Summer National Meeting. The Receivership Law (E) Working Group met six times in 2020 and 2021 to develop revisions to Section 5 of Model #440 and Section 19 of Model #450 that address the issue of continuation of essential services by affiliates in receivership. The Working Group will consider adoption of the amendments following the exposure period ending April 9, 2021.

**New Model: Real Property Lender-Placed Insurance Model Act**—The Executive (EX) Committee approved a Request for NAIC Model Law Development, submitted by the Property and Casualty Insurance (C) Committee, at the 2017 Summer National Meeting to draft the new Real Property Lender-Placed Insurance Model Act. The Lender-Placed Insurance Model Act (C) Working Group of the Property and Casualty Insurance (C) Committee exposed a draft of this proposed new model on Oct. 19, 2020, and adopted the model during its Nov. 13 meeting. The Property and Casualty Insurance (C) Committee adopted the model on Dec. 8, 2020, and the model will be considered by Executive (EX) Committee and Plenary on April 14, 2021.

**New Model: Pet Insurance Model Law**—The Executive (EX) Committee approved a Request for NAIC Model Law Development at the 2019 Summer National Meeting. The Pet Insurance (C) Working Group is meeting to draft the model law to define a regulatory structure for pet insurance and address issues such as: producer licensing; policy terms; coverages; claims handling; premium taxes; disclosures; arbitration; and preexisting conditions. The Working Group will request an extension of time to continue drafting the model during the Spring National Meeting. The Working Group has received comments on all sections of the new model and is now moving through revisions for final comment. The Working Group plans to consider adoption of the model later in 2021.

**New Model: Pharmacy Benefit Manager (PBM) Model Law**—The Executive (EX) Committee approved a Request for NAIC Model Law Development at the 2019 Summer National Meeting to draft a new model law addressing the licensure or registration of PBMs. The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force is drafting the model as a result of discussions that began during the Health Insurance and Managed Care (B) Committee’s work to revise the Health Carrier Prescription Drug Benefit Management Model Act (#22). Following the 2019 Summer National Meeting, the Working Group held several information-gathering sessions to assist it in working on its charge. The Working Group met in regulator-to-regulator session to discuss its next steps. The Working Group formed an ad hoc drafting group to develop an initial draft regulating PBMs. The Subgroup met July 16, 2020, to discuss a draft of establishing a PBM licensing requirement and other PBM provisions, including a gag clause provision. The Subgroup exposed the draft for a public comment period ending Sept. 1. The Subgroup discussed the comments received on the proposed new model during a series of meetings in September and October. The Subgroup adopted the proposed new model on Oct. 29 and forwarded it to the Regulatory Framework (B) Task Force for consideration of adoption. The Regulatory Framework (B) Task Force discussed the proposed new model during its Nov. 19 meeting. The Task Force deferred adopting the proposed new model and exposed it for an additional 30-day public comment period. The Task Force discussed the comments received on the proposed new model March 1 and adopted it March 18. The Health Insurance and Managed Care (B) Committee is expected to receive the new model during its April 12 meeting and defer adoption until it meets after the Spring National Meeting.

Attachment Six
Executive (EX) Committee
4/14/21

W:\National Meetings\2021\Spring\Cmte\Ex\Attr 6 Model Law Development Report.docx
CLIMATE AND RESILIENCY (EX) TASK FORCE

Climate and Resiliency (EX) Task Force April 9, 2021, Minutes .................................................................4-22
Climate Risk Disclosure Workstream Recommendation (Attachment One).........................................................4-26
The Climate and Resiliency (EX) Task Force met April 9, 2021. The following Task Force members participated: Ricardo Lara, Co-Chair (CA); Raymond G. Farmer, Co-Chair, and Kendall Buchanan (SC); Colin M. Hayashida, Co-Vice Chair (HI); James J. Donelon, Co-Vice Chair (LA); Kathleen A. Birrane, Co-Vice Chair (MD); Bruce R. Range, Co-Vice Chair (NE); Andrew R. Stolfi, Co-Vice Chair (OR); Lori K. Wing-Heier represented by Katie Hegland (AK); Jim L. Ridling (AL); Michael Conway represented by Peg Brown (CO); Trinidad Navarro represented by Frank Pyle (DE); David Altmair (FL); Stephen W. Robertson represented by Amy Beard (IN); Gary D. Anderson (MA); Eric A. Cioppa (ME); Anita G. Fox represented by Karen Dennis (MI); Grace Arnold (MN); Jon Godfrey represented by John Arnold (ND); Russel Toal represented by Anna Krylova (NY); Barbara D. Richardson (NV); Linda A. Lacewell represented by Nina Chen and Bob Kasinow (NY); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Scott A. White represented by Thomas J. Sanford (VA); Michael S. Pieciak represented by Rosemary Raszka (VT); Mike Kreidler (WA); Mark Aflable (WI); James A. Dodrill (WV); and Jeff Rude (WY). Also participating was: Judith L. French (OH).

1. **Adopted its 2020 Fall National Meeting Minutes**

   Commissioner Stolfi made a motion, seconded by Commissioner Altman, to adopt the Task Force’s Dec. 4, 2020, minutes (see *NAIC Proceedings – Fall 2020, Climate and Resiliency (EX) Task Force*). The motion passed unanimously.

2. **Received Reports from its Workstreams**

   Commissioner Birrane said the Solvency Workstream plans to hold a series of open meetings throughout the year to inform its recommendations regarding solvency matters related to climate risk. She said the Workstream members met Feb. 23 in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meeting, to create a workplan. The Workstream members also reviewed information compiled by the NAIC Capital Markets Bureau regarding climate-related investment data on U.S. insurers reporting to the NAIC. The information was compiled in response to a data request from the International Association of Insurance Supervisors (IAIS) as part of its 2021 Global Insurance Market Report (GIMAR). The NAIC Capital Markets Bureau compiled NAIC Annual Financial Statement data, including investment sectors prescribed by the IAIS. The data broke investments into six sectors, including energy, fossil fuels, housing, transportation, utilities and agriculture. The results show that the U.S. industry had approximately 13.8% of its total investments in stocks and bonds in all six sectors at year-end 2019. Investments in fossil fuels made up less than 3% of the industry’s total stocks and bonds at year-end 2019, a slight decrease from the prior year. The Workstream also sent a referral to the Catastrophe Risk (E) Subgroup to consider adding more perils to the Property/Casualty (P/C) Risk-Based Capital (RBC) formula. The formula currently includes hurricane and earthquake. The Subgroup is currently considering wildfire.

   Commissioner Hayashida said the Innovation Workstream is exploring the use of parametric insurance to fill coverage gaps related to natural catastrophe due to its growing popularity and interest both domestically and internationally. He said the Workstream met March 25 to hear two presentations. The first presenter, Carolyn Kousky (Wharton Risk Management and Decision Processes Center), described use cases for parametric insurance, including an upcoming study she is conducting to explore the use of parametric insurance for low-income households. Ms. Kousky described how parametric insurance could be stacked with a standard home or property policy to supplant excluded coverages or cover the cost of high deductibles or low limits. Ms. Kousky said macro-level parametric products could be used by the public sector to deter fiscal impacts to tax revenues and infrastructure or provide disaster assistance to citizens and businesses. The second presentation was provided by Emily Drake (NMCIC) and James West (NMCIC). They described a product developed by their company, Recoop Disaster Insurance. The product has been filed and approved in 33 states. The product is designed to offset high deductibles, actual cash value (ACV) provisions, expenses related to evacuation, and lost work time or job loss following a natural disaster. The policyholder must have a homeowners policy in place to obtain the coverage, and the triggering event is either a disaster declaration or a claim submission to their homeowners policy.

   Commissioner Donelon said the Technology Workstream met March 24 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings. During the meeting, the Center for Insurance Policy and Research (CIPR) and Risk Management Solutions (RMS) presented about their joint effort to create an application paper with benefit-cost analysis demonstrating mitigation activities.
proven to reduce wildfire risk. They also described an educational summary provided to state insurance regulators to explain the components of wildfire models, inputs, outputs, validation methods, and the application of models within regulatory functions.

3. **Received a Recommendation from the Climate Risk Disclosure Workstream**

Commissioner Stolfi said the Climate Risk Disclosure Workstream met several times in the first quarter 2021 to become familiar with alternative climate-reporting frameworks and hear from insurers, rating agencies, and state insurance regulators participating in the **NAIC Climate Risk Disclosure Survey** (Climate Survey). He said it has been noted that federal and international regulatory agencies are also reviewing the need for climate-risk disclosures, and the Workstream is staying abreast of those developments to promote consistency in reporting, where practicable. The Workstream developed a memo to the Task Force (Attachment One) recommending that the 2021 reporting framework remain consistent with the prior year 2020 reporting requirements. Beginning in 2020, insurers could file either the Climate Survey or the Task Force for Climate-Related Financial Disclosures (TCFD). This interim step, remaining consistent with prior years, provides the industry with ample time to prepare for its annual reporting requirement and the Workstream additional time to work through its considerations for improvements to the information obtained in the climate disclosures. Furthermore, it allows the Workstream to continue working with external stakeholders to promote a consistent approach across agencies. Currently, six states are participating: California, Connecticut, Minnesota, New Mexico, New York and Washington. All licensed insurers writing more than $100 million in premium in the participating states are required to file a climate disclosure annually. For several years, the Climate Survey has captured more than 70% of the U.S. market. Commissioner Stolfi said the Oregon Department of Consumer and Business Services is considering participating in 2021, and he encouraged other states to do so as well.

David F. Snyder (American Property Casualty Insurance Association—APCIA) commended the work of the Workstream and the flexibility for insurers to report either the Climate Survey or the TCFD in 2021. He acknowledged the challenges ahead, including time horizons, the definition of transition risk, moving from qualitative to quantitative reporting, and confidentiality measures.

Dennis C. Burke (Reinsurance Association of America—RAA) also commended the work of the Workstream and urged the members to recognize insurers’ need for flexibility in underwriting, risk management and decision processing. A one-size-fits-all approach would not benefit the industry, as companies vary in size and operation. Mr. Burke also encouraged the members to continue tracking domestic and international regulatory actions in this area to avoid duplicative reporting requirements for insurers.

Cate Paolino (National Association of Mutual Insurance Companies—NAMIC) encouraged state insurance regulators to take the preliminary step to create a clearly defined purpose for climate-risk disclosures, as well as the regulatory actions that drive the need for that information, such as solvency or consumer protection. She also encouraged the members to scope out and leverage existing reporting requirements to avoid duplicative requests for information from carriers, as well as ensure confidentiality, where appropriate. She urged any new states joining the disclosure initiative to consider the need for staggered deadlines or flexibility offered to new companies required to report in 2021.

Birny Birnbaum (Center for Economic Justice—CEJ) said there is opportunity for improvement of climate-related disclosures to include information for consumers and policymakers. He said more information is necessary for insureds and policymakers to be confident in the availability of coverage.

David Arkush (Public Citizen’s Climate Program) said he sent a letter to the Workstream leaders calling for more prompt action on climate-related disclosures. He said a greater sense of urgency is necessary, as domestic and international regulators are beginning to act on disclosures. He mentioned Connecticut Senate Bill 1047, which if enacted, would require that insurance companies disclose how much they receive annually in fossil fuel premiums and how much they invest in the fossil fuel industry, as well as the climate risk associated with those investments. He also said New York has already requested climate-related information from insurers and is demonstrating that it is possible to get started right away, learn and adjust, as necessary.

Commissioner Lara said the Task Force is seeking a strong and consistent climate-risk disclosure that positions the insurance sector as a leader. The Workstream has been working rapidly; holding public meetings every few weeks since January; hearing from experts in climate-risk disclosure, such as Principles for Responsible Investing and insurance companies that complete TCFD reports, such as Zurich; and thoroughly reviewing the existing Climate Survey. The goal is a robust and consistent disclosure across the insurance sector, and that will take continued work. This recommendation is initial, recognizing the need for insurers to start working on this year’s disclosure. The Workstream will continue meeting and working towards a robust and comprehensive recommendation on climate-risk disclosure.
4. **Heard a Presentation Regarding the Building Code and Mitigation Workshop**

Jennifer Gardner (NAIC) said under the leadership of Director Ramge, the Pre-Disaster Mitigation Workstream co-hosted a building code and mitigation workshop March 17–19 with the CIPR, as well as the Federal Alliance for Safe Homes Inc. (FLASH). Over 100 people attended, including staff from 17 departments of insurance (DOIs), federal and state emergency management agencies, industry representatives, and consumer advocates. The first day of the workshop was designed to provide a greater understanding of the framework for building code adoption and enforcement, how state DOIs can and do advocate for strong building codes, and how industry can support strong codes through incentives. Presentations included the International Code Council (ICC), the Insurance Institute for Building & Home Safety (IBHS), the Mississippi DOI, and the Insurance Services Office (ISO). Day two of the workshop focused on the science of mitigation; proven methods to reduce risk, state avenues for incentivizing mitigation, such as grant fund programs and insurance incentives, such as premium credits and discounts. Presentations included the Strengthen Alabama Homes program, the South Carolina Safe Home program, and Hawaii Senate Bill 1101. Additional presentations focused on the coordinated state management of risk reduction, such as the partnership between the California DOI and Governor Newsom’s office to reduce the risk of wildfire and Nebraska’s annual statewide emergency management agency report. The Federal Emergency Management Agency (FEMA) presented about its goal to align a FEMA federal and national strategy on building codes and resiliency. The final day of the workshop focused on pre- and post-disaster funding and included presentations from FEMA regarding federal grants, as well as its Federal Insurance and Mitigation Administration (FIMA) Strategic Plan. The purpose of FEMA’s plan is to show how mitigation investments reduce risk, coordinate mitigation investments to reduce risk, and make mitigation investment a standard practice. Bryan Koon presented on how IEM can work with states to submit grant applications for federal funding. Finally, Amy Bach (United Policyholders) presented on alternative funding mechanisms such as state, utility and forestry management resources. The meeting materials and recordings of the workshop are available on the Climate Risk and Resiliency Resource Center webpage at content.naic.org/climate-resiliency-resource.htm.

5. **Heard a Presentation on NAIC Communications Activities**

Laura Kane (NAIC) said the NAIC conducted a homeowners policyholder Climate Survey, capturing nearly 2,500 responses from March 9–16. The results show that 75% of respondents believe extreme weather events are happening more frequently because of climate change. 41% of respondents believe weather events have affected their risk of future losses to home or property, 40% do not believe weather events have affected their risk of future losses to home or property, and the final 19% are unsure. The NAIC Communications Department developed the #KnowYourRisks campaign to provide more information regarding flood and wildfire risks, including consumer toolkits and media communication. The Climate Survey results show that 56% of respondents believe flood is a covered peril under a standard homeowners policy. This assumption is untrue. Flood insurance is typically excluded under a standard homeowners policy unless added back by endorsement and showing a lack of understanding by most consumers. The NAIC designed an interactive #CoverYourRisks quiz, designed to help consumers better understand their risks, especially with respect to flooding. Ms. Kane said the NAIC also has a #ReduceYourRisk campaign to help guide consumers through the process of mitigating for losses from extreme weather, such as wildfire and severe winter weather. Acknowledging mitigation, the homeowners policyholder Climate Survey results showed that 71% of respondents would be willing to spend their own money to fortify their homes in exchange for a premium reduction of 1–10%. 99% of respondents would be willing to spend up to $500, 66% would be willing to spend up to $2,500, 24% would be willing to spend up to $5,000, and 8% would be willing to spend more than $5,000. Finally, Ms. Kane said the NAIC is revamping the home inventory mobile application this year to include additional functionality and consumer preparedness tools. The new tool will be released April 15.

6. **Heard an Update on Federal Activities**

Brooke Stringer (NAIC) said on Feb. 24, U.S. Securities Exchange Commissioner (SEC) Acting Chair Allison Herren Lee directed agency staff to begin work on revising 2010 guidance on climate-change disclosures by public companies. On March 15, the SEC solicited feedback on 15 questions intended to help develop a framework for climate-change disclosures. The request included 15 questions addressing issues, such as where and how climate-change disclosures should be provided, what information relating to climate risks can be quantified and measured, and whether there are any existing climate-disclosure frameworks that the SEC could rely on. Comments are due by June 13. The SEC is expected to develop rules that would require companies to disclose more information about their contributions to climate change and the related risks they face. The SEC also announced that it will be stepping up its focus on climate risk in its financial exams as one of its 2021 priorities.

The Federal Reserve has announced the creation of a new Financial Stability Climate Committee (FSCC) which will be tasked with identifying, assessing and addressing climate-related risks to financial stability. The FSCC is intended to complement the other recently created Supervision Climate Committee (SCC), which focuses on addressing risks at individual financial
institutions, and develop an appropriate program to ensure the resilience of supervised firms to those risks. Federal Reserve Governor Brainard in a speech at the Institute of International Finance endorsed moving toward mandatory climate-risk disclosures by financial institutions.

Financial Stability Oversight Council (FSOC) Treasury Secretary Janet Yellen presided over a FSOC meeting on March 31 that included an open session on climate change and its potential impact on financial stability. Superintendent Cioppa, an FSOC member, made remarks about state insurance regulators’ work in this area. Treasury Secretary Yellen said climate stress tests may be helpful for insurers and banks in terms of managing their risks. She noted that tests would be conducted by the Federal Reserve, and state insurance regulators might also consider a similar route.

Ms. Stringer said in March, the Commodity Futures Trading Commission (CFTC) announced the creation of a Climate Risk Unit to focus on the role of derivatives in understanding, pricing and addressing climate-related risk and transitioning to a low-carbon economy. She also said Senators Warren (D-MA), Van Hollen (D-MD), Whitehouse (D-RI) and Merkley (D-OR) wrote letters to eight insurers requesting information on how climate change will influence premiums and claims, what climate scenarios the insurers consider, what stress tests companies have conducted and what those exercises revealed about exposure to fossil fuel assets, and how companies’ fossil fuel underwriting and investing policies align with sustainability goals. The Senators requested responses from the insurers by April 16.

Finally, Ms. Stringer said Senator Feinstein (D-CA) and Rep. Casten (D-IL) have reintroduced the Addressing Climate Financial Risk Act (S. 588/ H.R.1549), which would direct the FSOC to create the Advisory Committee on Climate Risk, coordinate supervisory efforts, and direct the Federal Insurance Office (FIO) to develop a report on how to modernize and improve climate-risk insurance regulation.

7. Heard an Update on International Activities

Rashmi Sutton (NAIC) said the Sustainable Insurance Forum (SIF) met in March for the first time with its new chair, Anna Sweeney, of the United Kingdom (UK) Bank of England (BoE). Director Farmer represented the NAIC. California, New York and Washington also attended the meeting as SIF members. The FIO also recently joined the SIF. The SIF discussed the completion of the public consultation of the joint IAIS/SIF Application Paper on the Supervision of Climate-Related Risk and next steps for finalizing the paper (publication expected this summer) and providing capacity building to members relative to the guidance in the paper. Further, the SIF also discussed the start of the work of the three workstreams agreed to in its workplan: 1) impacts of climate-related risks on the insurability of assets; 2) broader sustainability issues beyond climate change; and 3) climate risks in the actuarial processes.

Ms. Sutton said the United Nations Environment Programme (UNEP) Finance Initiative (FI) Principles for Sustainable Insurance (PSI) produced a report developing comprehensive guidance for the insurance industry to identify and disclose the impact of climate change on its business. The Access to Insurance Initiative (A2ii), an implementation partner of the IAIS, will be hosting a series of dialogues focused on sustainability and managing climate-related risks. Information regarding those dialogues will be posted on the Climate Risk and Resiliency Resource Center webpage.

The Financial Stability Board (FSB) is building a report on the financial stability implications of climate change, which will assess the availability of data through which climate-related risks to financial stability could be monitored, as well as identify data gaps. The FSB will also coordinate with other standard-setting bodies to promote globally comparable, high-quality standards of disclosure and review state insurance regulator and supervisory approaches to addressing climate-related risks at financial institutions.

The NAIC International Insurance Forum will include a panel discussion on international climate-related risks. The panel will be moderated by Commissioner Mais, and panelists will discuss the evolution of how insurers and state insurance regulators consider climate risk; appropriate disclosures; the private sector’s role in resiliency; and preparatory strategies for addressing climate risk, such as through mitigation.

Finally, NAIC members continue to participate in international dialogues, which include issues related to climate risk and resiliency.

Having no further business, the Climate and Resiliency (EX) Task Force adjourned.
DRAFT MEMORANDUM

TO: Members of the Climate and Resiliency (EX) Task Force

FROM: Climate Risk Disclosure Workstream of the Climate and Resiliency (EX) Task Force

DATE: March 11, 2021

RE: Climate Risk Disclosure Workstream Update on Activities and Reporting Recommendations for 2021

The NAIC Climate and Resiliency (EX) Task Force charged the Climate Risk Disclosure Workstream to consider modifications to the NAIC Climate Risk Disclosure Survey (Appendix A) to align with the Recommendations of the Task Force on Climate-related Financial Disclosures (TCFD – Appendix B) and promote uniformity in reporting requirements. Appendix C shows the correlation between the NAIC Climate Risk Disclosure Survey and the TCFD.

This report serves as the workstream’s initial recommendation to the Climate and Resiliency (EX) Task Force. The initial recommendation does not complete the workstream’s charge. It provides an interim step to promote participation and provide direction for submitting the NAIC Climate Risk Disclosure Survey or the TCFD in 2021. It also provides direction for those involved in the reporting and aggregation process.

The workstream began holding weekly calls in January 2021 to gain information and perspectives around the NAIC Climate Risk Disclosure Survey and other climate disclosures. Most of the calls have been open to the industry and interested parties in order to ensure transparency of the process.

- On Jan. 27, the workstream heard from California about the history, administration, and collection process of the NAIC Climate Risk Disclosure Survey. It also heard from the NAIC Center for Insurance Policy and Research (CIPR) and the American Academy of Actuaries (Academy) on their analyses of the NAIC Climate Risk Disclosure Survey results.
- On Feb. 3, the Principles for Responsible Investment (PRI) and CDP North America each shared information on their climate reporting frameworks, including how they collect, manage, and store information.
- On Feb. 10, Ceres discussed its climate disclosure recommendations. Zurich Insurance Group and American International Group (AIG) also shared which climate disclosure frameworks they report to and their process of reporting to them.
- On Feb. 17, the workstream heard from RBC Global Asset Management and Sustainalytics—which provides environmental, social and governance (ESG) risk ratings—on how they each use climate disclosures, including the NAIC Climate Risk Disclosure Survey, in their risk assessments. The workstream also shared and asked for feedback on a list of questions it developed to help guide its work to define the objectives of the climate disclosures. At a high
level, these questions include: who the audience is for the disclosures; who should use the report; what framework should be used; how to design the questions; the timing of the report; the effective date of reporting; and where and how the results should be reported.

- On Feb. 24, the workstream met in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to hear from state insurance regulators who have analyzed the results of the information in the current survey and what they hope to improve in future versions.

- On March 3, the workstream met in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to draft its recommendations to the Task Force.

- On March 10, the workstream met to discuss its recommendations and hear feedback from the industry.

The workstream is also tracking what federal agencies and international organizations are doing relative to climate risk disclosure. On Feb. 24, the U.S. Securities and Exchange Commission (SEC) announced that it will begin reviewing the extent to which public companies are following its 2010 guidance on disclosure requirements related to climate change matters. The SEC will use insights from this work to begin updating the 2010 guidance to take into account developments in the past decade.

The United Kingdom will make the TCFD fully mandatory across the economy by 2025, with a significant portion of the mandatory requirements to be in place by 2023. New Zealand has announced its plans to mandate the TCFD by 2023. In January 2021, Switzerland officially became a supporter of the TCFD, calling on Swiss companies from all sectors of the economy to implement the disclosures on a voluntary basis. It also noted a bill should be drafted in the coming year to make the recommendations binding.

In response to growing interest and new disclosures from several large institutional investors, the Financial Stability Board (FSB), which created the TCFD, formed a working group to consider the benefits and challenges of disclosure of implied temperature rise. It will also consider implementing other forward-looking climate-related metrics and developing a set of questions for public consultation. The FSB task force will take consultation responses into consideration to determine whether further TCFD financial sector guidance on forward-looking metrics is needed. The FSB task force is expected to publish a status report in September 2021. Additionally, it is expected to do further analysis on the extent that companies describe the financial effect of climate-related risks and opportunities on their businesses and strategies.

Based on where most of the domestic and international groups are in their process of disclosure, we believe it is prudent to take a measured approach and allow additional time to determine a final recommendation. To support this process, the workstream developed a list of questions for state insurance regulators and interested parties. The workstream has invited comments from state insurance regulators and interested parties on the following questions:

1) Who is the audience and what do they wish to glean from the results?
   a) What qualitative and quantitative metrics do they need?
   b) How should the information in the survey be formatted to be useful?
2) Who should report?
   a) What is the threshold?
   b) Should it be compulsory?
   c) What states are participating?

3) What report framework should be used?
   a) TCFD?
   b) NAIC Climate Risk Disclosure Survey?
   c) Another framework (such as CDP)?
   d) Some combination?

4) How should the questions be designed?
   a) Multiple choice?
   b) Open-ended?
   c) Close-ended (rating scale, dropdown, ranking, etc.)?

5) When should the information be reported and what is the effective date of the changes?

6) Where should climate disclosures be reported?
   a) Continue to make it available through California’s website?
   b) Build an NAIC repository?
   c) Directed to the domestic state?

7) How should the results be made available?
   a) Only to regulators?
   b) Publicly available (as it is today)?

The workstream will consider the comments it received on these questions and revise them as appropriate before issuing them to state insurance regulators and interested parties for completion.

The workstream’s goal is to develop recommendations that address who should report, what will be reported, and how data will be collected and used in the future. Furthermore, the workstream plans to discuss how the survey results could be used within regulatory due process, for example, to encourage a discussion during company examinations.

After thoughtful deliberation, the workstream recommends maintaining the present disclosure reporting timing and structure for the 2021 reporting year, including which companies choose to submit either the NAIC Climate Risk Disclosure Survey or the TCFD. As shown in Appendix D, in 2020, 85 companies, including 9 insurer groups, submit the TCFD in lieu of the NAIC Climate Risk Disclosure Survey.

Revisions to the current disclosure reporting process is a multifaceted and complex project requiring sufficient depth of research and feedback from all parties affected or involved. The NAIC Climate Risk Disclosure Survey is administered in July. Given the proximity of this reporting date, there is insufficient time to make substantive changes to the questions or the California database that collects and houses the survey responses. The compressed time frame would also make it difficult for insurers to implement any more information-gathering processes and procedures.

The workstream also recommends that more states participate in the survey beginning in 2021. Inviting more companies to report will help capture a larger percentage of the market. Currently, six participating states require all their licensed companies writing more than $100 million in premium...
to report. As a result, approximately 70% of the U.S. market currently participates in the survey, meaning many of the domestic writers in nonparticipating states are already reporting or completing the NAIC Climate Risk Disclosure Survey or TCFD.

If more states agree to participate in 2021, it will increase the scope of the survey without making any changes to the survey questions or reporting framework. The workstream believes that more participation will be meaningful, even if the survey changes in 2022, as participating companies would benefit from the analysis the survey (or TCFD) requires and be better prepared for any future reporting.

Appendix D shows the list of companies currently reporting the NAIC Climate Risk Disclosure Survey, as well as those reporting the TCFD. More information about the TCFD will be added to the guidance provided to reporting companies (included in Appendix A) to encourage more insurers to report using the TCFD.

The workstream will continue to meet with stakeholders, including international and federal organizations, investors, consumer advocates, and the industry. This will provide the workstream time to make thoughtful recommendations and provide justification for any future changes to the NAIC Climate Risk Disclosure Survey and reporting framework to align with the TCFD as mandated. For example, the workstream will explore the use of multiple choice and open-ended questions, among other potential changes.
July 15, 2020

CLIMATE RISK DISCLOSURE SURVEY
REPORTING YEAR 2019

TO: Licensed Insurers in the State of California

In cooperation with the Connecticut Insurance Department, the Minnesota Department of Commerce, the New Mexico Office of Superintendent of Insurance, the New York Department of Financial Services, and the Washington State Office of the Insurance Commissioner, the California Department of Insurance is conducting the Climate Risk Disclosure Survey for Reporting Year 2019. The questions contained in the survey continue to be the same questions that were adopted by the National Association of Insurance Commissioners in 2009 and 2010. Survey responses for the current and prior years are available to the public and can be found on the Departments’ website.

All insurers who are licensed in the State of California and who collected direct written premium amounts of more than 100 million dollars nationwide during 2019 must respond to the survey for California; except for insurers required to respond to the survey by Connecticut, New Mexico, Minnesota, New York, or Washington. Insurers within the same group whose policies and practices are the same and whose answers would not be materially different from each other may submit uniform group responses.

We would like to highlight that the responses to the eight NAIC survey questions have substantial overlap with the guidelines and recommendations developed by the Task Force on Climate-related FinancialDisclosures (TCFD), which were approved by the G-20 Finance Ministers and created by an industry-led task force. The TCFD Guidelines are endorsed by many institutions and supported by the International Association of Insurance Supervisors. Please note that this year insurers will be given the option to submit a TCFD report in lieu of submitting a Climate Risk Disclosure Survey. To submit a TCFD report, click on the link below to register and follow the steps as if you are submitting a survey. You will then see the link to upload your TCFD report.

The NAIC annual climate survey and TCFD recommendations are similar, since they report on climate-related risks and opportunities, innovative products, such as premium reductions for risk mitigation efforts, green building insurance, renewable energy, natural infrastructure, or others. The TCFD recommendations also call on respondents to undertake a “scenario analysis” on effects of various climate outcomes on the company. More information on the TCFD recommendations can be found at the link below. We encourage you to refer to this information as you develop this year’s responses to the eight NAIC survey questions, even if you don’t have a TCFD report to submit. By doing so, U.S. insurers will assume a leadership position in applying this national standard.


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The completed survey is due August 31, 2020. Please register and submit your survey responses to the Department by going to the survey registration webpage at the following link: https://interactive.web.insurance.ca.gov/apex_extprd/f?p=416:1. Additional information concerning the survey is available on the survey registration webpage. Substantive and technical questions can be directed to: ClimateRiskSurvey@insurance.ca.gov.

Your cooperation is appreciated,

RICARDO LARA,
Insurance Commissioner

Attachment: Survey Questions and Guidelines
Climate Risk Disclosure Survey Guidance  
Reporting Year 2019

This document offers guidance to insurers responding to the annual mandatory Insurer Climate Risk Disclosure Survey (hereafter referred to as the “Survey”). Those questions contained in this guidance document which are not part of the official set of Survey questions are intended only to guide respondents as they craft their responses to the Survey and are not compulsory.

Guidance Notes

Survey Application and Instructions

i. Response Submissions

Mandatory disclosure will depend on the premium amounts reported for the most immediate prior financial reporting year. If an insurer reports over $100,000,000 on its Annual Schedule T filing with the NAIC, it must complete the survey. However, if an insurer reports less than that, it will not be required to complete and file the survey, but it may do so voluntarily. *Please note beginning this year if you would like to submit a TCFD (Task Force on Climate-related Financial Disclosures; https://www.fsb-tcfd.org/) report in lieu of submitting a survey you may do so.

ii. Quantitative and Forward-Looking Information

Insurers are not required to submit quantitative information but may do so without implying materiality. Insurers are encouraged to provide quantitative information where it offers additional clarity on trends in the intensity or attenuation of natural hazards, insured losses, investment portfolio composition, policyholder risk reduction or improvements in computer modeling. As climate science improves (i.e., when there is greater agreement between observed data and models or when there is integration of catastrophe and climate models), insurers should be able to provide quantitative information with less uncertainty.

Insurers are required to answer all questions in good faith and with meaningful responses. However, there is no requirement to provide information that is immaterial to an assessment of financial soundness (insurers may choose to disclose such information voluntarily, with no implication that such information is in fact material).

Insurers are encouraged but not required to provide forward-looking information that will indicate the risks and opportunities insurers may face in the future; when provided, insurers may disclaim any responsibility for the accuracy of such forward-looking information. Forward-looking information is assumed to have some degree of uncertainty; if provided, insurers should offer explanation on the degree and sources of uncertainty as well as assumptions employed.

iii. Response Required

Insurers in all segments of the industry are required to respond to all eight questions. An insurer may state that a question is not relevant to its business practice, operations or investments. However, if it does so, it must also explain why the question is not relevant. *Please note if you submit a TCFD report you will not be required to submit a survey.

Narrative responses are acceptable. Where an insurer’s response to other disclosure
Climate Risk Disclosure Survey Guidance
Reporting Year 2019

mechanisms, such as the Carbon Disclosure Project (CDP) or Global Reporting Initiative, explicitly addresses the subject matter of a question in this survey, the insurer may use their most recent response to that external mechanism.
Climate Risk Disclosure Survey Guidance
Reporting Year 2019

Survey Questions

Question One: Does the company have a plan to assess, reduce or mitigate its emissions in its operations or organizations?

Yes - The company has a plan to assess and reduce or mitigate emissions in our operations or organizations - Please summarize.
No - The company does not have a plan to assess and reduce or mitigate emissions in our operations or organizations - Please describe why not.

Insurers who are unfamiliar with frameworks for greenhouse gas emission measurement and management are encouraged to review the principles of “The Greenhouse Gas Protocol: A Corporate Accounting and Reporting Standard (Revised Edition)” developed by the World Resources Institute and the World Business Council for Sustainable Development (“the GHG Protocol”).

Each insurer is encouraged to clarify whether its plan for measuring and management of its emissions in operations and/or its subsidiary organizations’ operations includes emissions related to energy use for data storage or other computing-intensive processes.1

Question Two: Does the company have a climate change policy with respect to risk management and investment management? If yes, please summarize. If no, how do you account for climate change in your risk management?

Yes - The company has a climate change policy with respect to risk management and investment management - Please summarize.
No - The company does not have a climate change policy with respect to risk management and investment management - Please describe how you account for climate change in your risk management, or why you do not account for climate change in your risk management.

Questions to consider include:

- Where in the structure of the company is climate risk addressed?
- Does the company approach climate change as an Enterprise Risk Management (ERM) issue?
- Does the company have a dedicated point-person or team within the company that is responsible for managing its climate change strategy?
- What is the role of the board of directors in governing climate risk management?
- Does the company consider potentially correlated risks affecting asset management and underwriting?
- Has the company issued a public statement on its climate policy

1 Data centers consume more energy than any other area of an organization because they contain both IT equipment and the infrastructure that is needed to cool that equipment. The Environmental Protection Agency found that data centers consumed about 60 billion kilowatt- hours (kWh) in 2006, roughly 1.5 percent of total U.S. electricity consumption. Nancy Feig, Insurance & Technology “The Greening of Data Centers” Mar 07, 2008. URL: https://www.insurancetech.com/data-and-analytics/the-greening-of-data-centers/d/d-id/1310251.html
Climate Risk Disclosure Survey Guidance  
Reporting Year 2019

**Question Three:** Describe your company's process for identifying climate change-related risks and assessing the degree that they could affect your business, including financial implications.

*Yes - The company has a process for identifying climate change-related risks and assessing the degree that it could affect our business including financial implications - Please summarize.*

*No - The company does not have a process for identifying climate change-related risks and assessing the degree that it could affect our business including financial implications - Please describe why not.*

Questions to consider include:

- How may climate change shift customer demand for products?
- What implications may climate change have on liquidity and capital needs?
- How might climate change affect limits, cost and terms of catastrophe reinsurance, including reinstatement provisions?
- Has the insurer considered creative methods of risk distribution such as contingency plans to reduce financial leverage and resolve any liquidity issues in the event of a sudden loss in surplus and cash outflows as a result of a catastrophic event?
- How are these impacts likely to evolve over time? Does the company have plans to regularly reassess climate change related risks and its responses to those risks?

**Question Four:** Summarize the current or anticipated risks that climate change poses to your company. Explain the ways that these risks could affect your business. Include identification of the geographical areas affected by these risks.

*Yes - The company has identified current or anticipated risks that climate change poses to our company - Explain the ways that these risks could affect your business - Include identification of the geographical areas affected by these risks.*

*No - The company has not identified current or anticipated risks that climate change will pose to our company - Please describe why not.*

Questions to consider include:

- Which business segments or products are most exposed to climate-related risks?
- Has the company considered its potential exposure to climate liability through its D&O or CGL policies?
- Are there geographic locations, perils or coverages for which the company has increased rates, limited sales, or limited or eliminated coverages because of catastrophic events? How do those actions relate to assessments of climate change impacts made by the company?
- Has the company examined the geographic spread of property exposures relative to the expected impacts of climate change, including a review of the controls in place to assure that the insurer is adequately addressing its net exposure to catastrophic risk?
Climate Risk Disclosure Survey Guidance
Reporting Year 2019

**Question Five**: Has the company considered the impact of climate change on its investment portfolio? Has it altered its investment strategy in response to these considerations? If so, please summarize steps you have taken.

Yes - The company has considered the impact of climate change on its investment portfolio - Please summarize.
No - The company has not considered the impact of climate change on its investment portfolio - Please describe why not.

Yes - The company has altered its investment strategy in response to these considerations - Please summarize steps you have taken.
No - The company has not altered its investment strategy in response to these considerations - Please describe why not.

Questions to consider include:

- Does the company consider regulatory, physical, litigation, and competitiveness-related climate risks, among others, when assessing investments?
- Has the company considered the implications of climate change for all of its investment classes, e.g. equities, fixed income, infrastructure, real estate?
- Does the insurer use a shadow price for carbon when considering investments in heavy emitting industries in markets where carbon is either currently regulated or is likely to be regulated in the future?
- Does the insurer factor the physical risks of climate change (water scarcity, extreme events, weather variability) into security analysis or portfolio construction? If so, for what asset classes and issuers (corporate, sovereign, municipal)?
- How does climate change rank compared to other risk drivers, given the insurer’s asset liability matching strategy and investment duration?
- Does the insurer have a system in place to manage correlated climate risks between its underwriting and investments?

**Question Six**: Summarize steps the company has taken to encourage policyholders to reduce the losses caused by climate change-influenced events.

Yes - The company has taken steps to encourage policyholders to reduce the losses caused by climate change-influenced events - Please summarize.
No - The company has not taken steps to encourage policyholders to reduce the losses caused by climate change-influenced events - Please describe why not.

Questions to consider include:

- How has the company employed price incentives, new products or financial assistance to promote policyholder loss mitigation? In what lines have these efforts been attempted, and can the outcome of such efforts be quantified in terms of properties retrofitted, losses avoided, etc.?
- For insurers underwriting D&O, CGL and professional liability policies, what steps has the company taken to educate clients on climate liability risks or to screen potential policyholders based on climate liability risk? How does the company define climate risk for these lines?
Climate Risk Disclosure Survey Guidance
Reporting Year 2019

Question Seven: Discuss steps, if any, the company has taken to engage key constituencies on the topic of climate change.

Yes - The company has taken steps to engage key constituencies on the topic of climate change - Please summarize.
No - The company has not taken steps to engage key constituencies on the topic of climate change - Please describe why not.

Questions to consider include:
• How has the company supported improved research and/or risk analysis on the impacts of climate change?
• What resources has it invested to improve climate awareness among its customers in regulated and unregulated lines?
• What steps has it taken to educate shareholders on potential climate change risks the company faces?

Question Eight: Describe actions the company is taking to manage the risks climate change poses to your business including, in general terms, the use of computer modeling.

Yes - The company is taking actions to manage the risks climate change poses to the business - Please summarize what actions the company is taking and in general terms the use if any of computer modeling.
No - The company is not taking actions to manage the risks climate change poses to the business - Please describe why.

Questions to consider include:
• For what perils does the company believe that future trends may deviate substantially from historical trends due to changes in the hazard? Similarly, for what perils, if any, does the company believe that a catastrophe model extrapolating observed trends would be insufficient to plan for maximum possible loss or yearly average loss? What steps has the company taken to model or analyze perils associated with non-stationary hazards?
• Has the company used catastrophe models to conduct hypothetical “stress tests” to determine the implications of a wide range of plausible climate change scenarios? If so, over what timescale, in what geographies and for what perils?
• Has the company conducted, commissioned or participated in scenario modeling for climate trends beyond the 1-5 year timescale? If so, what conclusions did the company reach on the potential implications for insurability under these scenarios?
Climate Change Resources for Insurers

There are many publications and websites that can provide insurers with a useful overview of the potential impacts of climate change on the insurance sector. The following resource list is not comprehensive but offers a good starting point for insurers seeking more information on the scientific basis of climate change, risks to insurers, catastrophe modeling, public policy, liability, risk management and impacts on insurer investments.

Impacts of Climate Change on the Insurance Sector


Life and Health Insurers and Climate Change


Climate Change Disclosure


Carbon Disclosure Project (“CDP”) URL: https://www.cdp.net/en


Climate Change Science

July 15, 2020

CLIMATE RISK DISCLOSURE SURVEY
REPORTING YEAR 2019

TO: Licensed Insurers in the State of California

In cooperation with the Connecticut Insurance Department, the Minnesota Department of Commerce, the New Mexico Office of Superintendent of Insurance, the New York Department of Financial Services, and the Washington State Office of the Insurance Commissioner, the California Department of Insurance is conducting the Climate Risk Disclosure Survey for Reporting Year 2019. The questions contained in the survey continue to be the same questions that were adopted by the National Association of Insurance Commissioners in 2009 and 2010. Survey responses for the current and prior years are available to the public and can be found on the Departments’ website.

All insurers who are licensed in the State of California and who collected direct written premium amounts of more than 100 million dollars nationwide during 2019 must respond to the survey for California; except for insurers required to respond to the survey by Connecticut, New Mexico, Minnesota, New York, or Washington. Insurers within the same group whose policies and practices are the same and whose answers would not be materially different from each other may submit uniform group responses.

We would like to highlight that the responses to the eight NAIC survey questions have substantial overlap with the guidelines and recommendations developed by the Task Force on Climate-related Financial Disclosures (TCFD), which were approved by the G-20 Finance Ministers and created by an industry-led task force. The TCFD Guidelines are endorsed by many institutions and supported by the International Association of Insurance Supervisors. Please note that this year insurers will be given the option to submit a TCFD report in lieu of submitting a Climate Risk Disclosure Survey. To submit a TCFD report, click on the link below to register and follow the steps as if you are submitting a survey. You will then see the link to upload your TCFD report.

The NAIC annual climate survey and TCFD recommendations are similar, since they report on climate-related risks and opportunities, innovative products, such as premium reductions for risk mitigation efforts, green building insurance, renewable energy, natural infrastructure, or others. The TCFD recommendations also call on respondents to undertake a “scenario analysis” on effects of various climate outcomes on the company. More information on the TCFD recommendations can be found at the link below. We encourage you to refer to this information as you develop this year’s responses to the eight NAIC survey questions, even if you don’t have a TCFD report to submit. By doing so, U.S. insurers will assume a leadership position in applying this national standard.

The completed survey is due **August 31, 2020**. Please register and submit your survey responses to the Department by going to the survey registration webpage at the following link: [https://interactive.web.insurance.ca.gov/apex_extprd/f?p=416:1](https://interactive.web.insurance.ca.gov/apex_extprd/f?p=416:1). Additional information concerning the survey is available on the survey registration webpage. Substantive and technical questions can be directed to: ClimateRiskSurvey@insurance.ca.gov.

Your cooperation is appreciated,

RICARDO LARA,
Insurance Commissioner

Attachment: Survey Questions and Guidelines
Climate Risk Disclosure Survey Guidance
Reporting Year 2019

This document offers guidance to insurers responding to the annual mandatory Insurer Climate Risk Disclosure Survey (hereafter referred to as the “Survey”). Those questions contained in this guidance document which are not part of the official set of Survey questions are intended only to guide respondents as they craft their responses to the Survey and are not compulsory.

Guidance Notes

Survey Application and Instructions

i. Response Submissions

Mandatory disclosure will depend on the premium amounts reported for the most immediate prior financial reporting year. If an insurer reports over $100,000,000 on its Annual Schedule T filing with the NAIC, it must complete the survey. However, if an insurer reports less than that, it will not be required to complete and file the survey, but it may do so voluntarily. *Please note beginning this year if you would like to submit a TCFD (Task Force on Climate-related Financial Disclosures; https://www.fsb-tcfd.org/) report in lieu of submitting a survey you may do so.

ii. Quantitative and Forward-Looking Information

Insurers are not required to submit quantitative information but may do so without implying materiality. Insurers are encouraged to provide quantitative information where it offers additional clarity on trends in the intensity or attenuation of natural hazards, insured losses, investment portfolio composition, policyholder risk reduction or improvements in computer modeling. As climate science improves (i.e., when there is greater agreement between observed data and models or when there is integration of catastrophe and climate models), insurers should be able to provide quantitative information with less uncertainty.

Insurers are required to answer all questions in good faith and with meaningful responses. However, there is no requirement to provide information that is immaterial to an assessment of financial soundness (insurers may choose to disclose such information voluntarily, with no implication that such information is in fact material).

Insurers are encouraged but not required to provide forward-looking information that will indicate the risks and opportunities insurers may face in the future; when provided, insurers may disclaim any responsibility for the accuracy of such forward-looking information. Forward-looking information is assumed to have some degree of uncertainty; if provided, insurers should offer explanation on the degree and sources of uncertainty as well as assumptions employed.

iii. Response Required

Insurers in all segments of the industry are required to respond to all eight questions. An insurer may state that a question is not relevant to its business practice, operations or investments. However, if it does so, it must also explain why the question is not relevant. *Please note if you submit a TCFD report you will not be required to submit a survey.

Narrative responses are acceptable. Where an insurer’s response to other disclosure
Climate Risk Disclosure Survey Guidance
Reporting Year 2019

mechanisms, such as the Carbon Disclosure Project (CDP) or Global Reporting Initiative, explicitly addresses the subject matter of a question in this survey, the insurer may use their most recent response to that external mechanism.
Climate Risk Disclosure Survey Guidance
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Survey Questions

Question One: Does the company have a plan to assess, reduce or mitigate its emissions in its operations or organizations?

Yes - The company has a plan to assess and reduce or mitigate emissions in our operations or organizations - Please summarize.

No - The company does not have a plan to assess and reduce or mitigate emissions in our operations or organizations - Please describe why not.

Insurers who are unfamiliar with frameworks for greenhouse gas emission measurement and management are encouraged to review the principles of “The Greenhouse Gas Protocol: A Corporate Accounting and Reporting Standard (Revised Edition)” developed by the World Resources Institute and the World Business Council for Sustainable Development (“the GHG Protocol”).

Each insurer is encouraged to clarify whether its plan for measuring and management of its emissions in operations and/or its subsidiary organizations’ operations includes emissions related to energy use for data storage or other computing-intensive processes.1

Question Two: Does the company have a climate change policy with respect to risk management and investment management? If yes, please summarize. If no, how do you account for climate change in your risk management?

Yes - The company has a climate change policy with respect to risk management and investment management - Please summarize.

No - The company does not have a climate change policy with respect to risk management and investment management - Please describe how you account for climate change in your risk management, or why you do not account for climate change in your risk management.

Questions to consider include:

• Where in the structure of the company is climate risk addressed?
• Does the company approach climate change as an Enterprise Risk Management (ERM) issue?
• Does the company have a dedicated point-person or team within the company that is responsible for managing its climate change strategy?
• What is the role of the board of directors in governing climate risk management?
• Does the company consider potentially correlated risks affecting asset management and underwriting?
• Has the company issued a public statement on its climate policy

1 Data centers consume more energy than any other area of an organization because they contain both IT equipment and the infrastructure that is needed to cool that equipment. The Environmental Protection Agency found that data centers consumed about 60 billion kilowatt-hours (kWh) in 2006, roughly 1.5 percent of total U.S. electricity consumption. Nancy Feig, Insurance & Technology “The Greening of Data Centers” Mar 07, 2008. URL: https://www.insurancetech.com/data-and-analytics/the-greening-of-data-centers/d/d-id/1310251.html
Climate Risk Disclosure Survey Guidance
Reporting Year 2019

**Question Three:** Describe your company's process for identifying climate change-related risks and assessing the degree that they could affect your business, including financial implications.

*Yes - The company has a process for identifying climate change-related risks and assessing the degree that it could affect our business including financial implications - Please summarize.*

*No - The company does not have a process for identifying climate change-related risks and assessing the degree that it could affect our business including financial implications - Please describe why not.*

Questions to consider include:
- How may climate change shift customer demand for products?
- What implications may climate change have on liquidity and capital needs?
- How might climate change affect limits, cost and terms of catastrophe reinsurance, including reinstatement provisions?
- Has the insurer considered creative methods of risk distribution such as contingency plans to reduce financial leverage and resolve any liquidity issues in the event of a sudden loss in surplus and cash outflows as a result of a catastrophic event?
- How are these impacts likely to evolve over time? Does the company have plans to regularly reassess climate change related risks and its responses to those risks?

**Question Four:** Summarize the current or anticipated risks that climate change poses to your company. Explain the ways that these risks could affect your business. Include identification of the geographical areas affected by these risks.

*Yes - The company has identified current or anticipated risks that climate change poses to our company - Explain the ways that these risks could affect your business - Include identification of the geographical areas affected by these risks.*

*No - The company has not identified current or anticipated risks that climate change will pose to our company - Please describe why not.*

Questions to consider include:
- Which business segments or products are most exposed to climate-related risks?
- Has the company considered its potential exposure to climate liability through its D&O or CGL policies?
- Are there geographic locations, perils or coverages for which the company has increased rates, limited sales, or limited or eliminated coverages because of catastrophic events? How do those actions relate to assessments of climate change impacts made by the company?
- Has the company examined the geographic spread of property exposures relative to the expected impacts of climate change, including a review of the controls in place to assure that the insurer is adequately addressing its net exposure to catastrophic risk?
Question Five: *Has the company considered the impact of climate change on its investment portfolio? Has it altered its investment strategy in response to these considerations? If so, please summarize steps you have taken.*

Yes - *The company has considered the impact of climate change on its investment portfolio - Please summarize.*

No - *The company has not considered the impact of climate change on its investment portfolio - Please describe why not.*

Yes - *The company has altered its investment strategy in response to these considerations - Please summarize steps you have taken.*

No - *The company has not altered its investment strategy in response to these considerations - Please describe why not.*

Questions to consider include:

- Does the company consider regulatory, physical, litigation, and competitiveness-related climate risks, among others, when assessing investments?
- Has the company considered the implications of climate change for all of its investment classes, e.g. equities, fixed income, infrastructure, real estate?
- Does the insurer use a shadow price for carbon when considering investments in heavy emitting industries in markets where carbon is either currently regulated or is likely to be regulated in the future?
- Does the insurer factor the physical risks of climate change (water scarcity, extreme events, weather variability) into security analysis or portfolio construction? If so, for what asset classes and issuers (corporate, sovereign, municipal)?
- How does climate change rank compared to other risk drivers, given the insurer’s asset liability matching strategy and investment duration?
- Does the insurer have a system in place to manage correlated climate risks between its underwriting and investments?

Question Six: *Summarize steps the company has taken to encourage policyholders to reduce the losses caused by climate change-influenced events.*

Yes - *The company has taken steps to encourage policyholders to reduce the losses caused by climate change-influenced events - Please summarize.*

No - *The company has not taken steps to encourage policyholders to reduce the losses caused by climate change-influenced events - Please describe why not.*

Questions to consider include:

- How has the company employed price incentives, new products or financial assistance to promote policyholder loss mitigation? In what lines have these efforts been attempted, and can the outcome of such efforts be quantified in terms of properties retrofitted, losses avoided, etc.?
- For insurers underwriting D&O, CGL and professional liability policies, what steps has the company taken to educate clients on climate liability risks or to screen potential policyholders based on climate liability risk? How does the company define climate risk for these lines?
Climate Risk Disclosure Survey Guidance
Reporting Year 2019

*Question Seven:* Discuss steps, if any, the company has taken to engage key constituencies on the topic of climate change.

**Yes -** The company has taken steps to engage key constituencies on the topic of climate change - Please summarize.

**No -** The company has not taken steps to engage key constituencies on the topic of climate change - Please describe why not.

Questions to consider include:
- How has the company supported improved research and/or risk analysis on the impacts of climate change?
- What resources has it invested to improve climate awareness among its customers in regulated and unregulated lines?
- What steps has it taken to educate shareholders on potential climate change risks the company faces?

*Question Eight:* Describe actions the company is taking to manage the risks climate change poses to your business including, in general terms, the use of computer modeling.

**Yes -** The company is taking actions to manage the risks climate change poses to the business - Please summarize what actions the company is taking and in general terms the use if any of computer modeling.

**No -** The company is not taking actions to manage the risks climate change poses to the business - Please describe why.

Questions to consider include:
- For what perils does the company believe that future trends may deviate substantially from historical trends due to changes in the hazard? Similarly, for what perils, if any, does the company believe that a catastrophe model extrapolating observed trends would be insufficient to plan for maximum possible loss or yearly average loss? What steps has the company taken to model or analyze perils associated with non-stationary hazards?
- Has the company used catastrophe models to conduct hypothetical “stress tests” to determine the implications of a wide range of plausible climate change scenarios? If so, over what timescale, in what geographies and for what perils?
- Has the company conducted, commissioned or participated in scenario modeling for climate trends beyond the 1-5 year timescale? If so, what conclusions did the company reach on the potential implications for insurability under these scenarios?
Climate Change Resources for Insurers

There are many publications and websites that can provide insurers with a useful overview of the potential impacts of climate change on the insurance sector. The following resource list is not comprehensive but offers a good starting point for insurers seeking more information on the scientific basis of climate change, risks to insurers, catastrophe modeling, public policy, liability, risk management and impacts on insurer investments.

Impacts of Climate Change on the Insurance Sector


Life and Health Insurers and Climate Change


Climate Change Disclosure

Carbon Disclosure Project (“CDP”) URL: https://www.cdp.net/en

Global Reporting Initiative (“GRI”) URL: https://www.globalreporting.org

Climate Change Science
Final Report

Recommendations of the Task Force on Climate-related Financial Disclosures

TCFD

Task Force on Climate-related Financial Disclosures

June 2017
June 15, 2017

Letter from Michael R. Bloomberg

Mr. Mark Carney
Chairman
Financial Stability Board
Bank for International Settlements
Centralbahnplatz 2
CH-4002 Basel
Switzerland

Dear Chairman Carney,

On behalf of the Task Force on Climate-related Financial Disclosures, I am pleased to present this final report setting out our recommendations for helping businesses disclose climate-related financial information.

As you know, warming of the planet caused by greenhouse gas emissions poses serious risks to the global economy and will have an impact across many economic sectors. It is difficult for investors to know which companies are most at risk from climate change, which are best prepared, and which are taking action.

The Task Force's report establishes recommendations for disclosing clear, comparable and consistent information about the risks and opportunities presented by climate change. Their widespread adoption will ensure that the effects of climate change become routinely considered in business and investment decisions. Adoption of these recommendations will also help companies better demonstrate responsibility and foresight in their consideration of climate issues. That will lead to smarter, more efficient allocation of capital, and help smooth the transition to a more sustainable, low-carbon economy.

The industry Task Force spent 18 months consulting with a wide range of business and financial leaders to hone its recommendations and consider how to help companies better communicate key climate-related information. The feedback we received in response to the Task Force's draft report confirmed broad support from industry and others, and involved productive dialogue among companies and banks, insurers, and investors. This was and remains a collaborative process, and as these recommendations are implemented, we hope that this dialogue and feedback continues.

Since the Task Force began its work, we have also seen a significant increase in demand from investors for improved climate-related financial disclosures. This comes amid unprecedented support among companies for action to tackle climate change.

I want to thank the Financial Stability Board for its leadership in promoting better disclosure of climate-related financial risks, and for its support of the Task Force's work. I am also grateful to the Task Force members and Secretariat for their extensive contributions and dedication to this effort.

The risk climate change poses to businesses and financial markets is real and already present. It is more important than ever that businesses lead in understanding and responding to these risks—and seizing the opportunities—to build a stronger, more resilient, and sustainable global economy.

Sincerely,

Michael R. Bloomberg
Executive Summary

Financial Markets and Transparency
One of the essential functions of financial markets is to price risk to support informed, efficient capital-allocation decisions. Accurate and timely disclosure of current and past operating and financial results is fundamental to this function, but it is increasingly important to understand the governance and risk management context in which financial results are achieved. The financial crisis of 2007-2008 was an important reminder of the repercussions that weak corporate governance and risk management practices can have on asset values. This has resulted in increased demand for transparency from organizations on their governance structures, strategies, and risk management practices. Without the right information, investors and others may incorrectly price or value assets, leading to a misallocation of capital.

Increasing transparency makes markets more efficient and economies more stable and resilient.
—Michael R. Bloomberg

Financial Implications of Climate Change
One of the most significant, and perhaps most misunderstood, risks that organizations face today relates to climate change. While it is widely recognized that continued emission of greenhouse gases will cause further warming of the planet and this warming could lead to damaging economic and social consequences, the exact timing and severity of physical effects are difficult to estimate. The large-scale and long-term nature of the problem makes it uniquely challenging, especially in the context of economic decision making. Accordingly, many organizations incorrectly perceive the implications of climate change to be long term and, therefore, not necessarily relevant to decisions made today.

The potential impacts of climate change on organizations, however, are not only physical and do not manifest only in the long term. To stem the disastrous effects of climate change within this century, nearly 200 countries agreed in December 2015 to reduce greenhouse gas emissions and accelerate the transition to a lower-carbon economy. The reduction in greenhouse gas emissions implies movement away from fossil fuel energy and related physical assets. This coupled with rapidly declining costs and increased deployment of clean and energy-efficient technologies could have significant, near-term financial implications for organizations dependent on extracting, producing, and using coal, oil, and natural gas. While such organizations may face significant climate-related risks, they are not alone. In fact, climate-related risks and the expected transition to a lower-carbon economy affect most economic sectors and industries. While changes associated with a transition to a lower-carbon economy present significant risk, they also create significant opportunities for organizations focused on climate change mitigation and adaptation solutions.

For many investors, climate change poses significant financial challenges and opportunities, now and in the future. The expected transition to a lower-carbon economy is estimated to require around $1 trillion of investments a year for the foreseeable future, generating new investment opportunities. At the same time, the risk-return profile of organizations exposed to climate-related risks may change significantly as such organizations may be more affected by physical impacts of climate change, climate policy, and new technologies. In fact, a 2015 study estimated the value at risk, as a result of climate change, to the total global stock of manageable assets as

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ranging from $4.2 trillion to $43 trillion between now and the end of the century. The study highlights that “much of the impact on future assets will come through weaker growth and lower asset returns across the board.” This suggests investors may not be able to avoid climate-related risks by moving out of certain asset classes as a wide range of asset types could be affected. Both investors and the organizations in which they invest, therefore, should consider their longer-term strategies and most efficient allocation of capital. Organizations that invest in activities that may not be viable in the longer term may be less resilient to the transition to a lower-carbon economy, and their investors will likely experience lower returns. Compounding the effect on longer-term returns is the risk that present valuations do not adequately factor in climate-related risks because of insufficient information. As such, long-term investors need adequate information on how organizations are preparing for a lower-carbon economy.

Furthermore, because the transition to a lower-carbon economy requires significant and, in some cases, disruptive changes across economic sectors and industries in the near term, financial policymakers are interested in the implications for the global financial system, especially in terms of avoiding financial dislocations and sudden losses in asset values. Given such concerns and the potential impact on financial intermediaries and investors, the G20 Finance Ministers and Central Bank Governors asked the Financial Stability Board to review how the financial sector can take account of climate-related issues. As part of its review, the Financial Stability Board identified the need for better information to support informed investment, lending, and insurance underwriting decisions and improve understanding and analysis of climate-related risks and opportunities. Better information will also help investors engage with companies on the resilience of their strategies and capital spending, which should help promote a smooth rather than an abrupt transition to a lower-carbon economy.

Task Force on Climate-related Financial Disclosures

To help identify the information needed by investors, lenders, and insurance underwriters to appropriately assess and price climate-related risks and opportunities, the Financial Stability Board established an industry-led task force: the Task Force on Climate-related Financial Disclosures (Task Force). The Task Force was asked to develop voluntary, consistent climate-related financial disclosures that would be useful to investors, lenders, and insurance underwriters in understanding material risks. The 32-member Task Force is global; its members were selected by the Financial Stability Board and come from various organizations, including large banks, insurance companies, asset managers, pension funds, large non-financial companies, accounting and consulting firms, and credit rating agencies. In its work, the Task Force drew on member expertise, stakeholder engagement, and existing climate-related disclosure regimes to develop a singular, accessible framework for climate-related financial disclosure.

The Task Force developed four widely adoptable recommendations on climate-related financial disclosures that are applicable to organizations across sectors and jurisdictions (Figure 1). Importantly, the Task Force’s recommendations apply to financial-sector organizations, including banks, insurance companies, asset managers, and asset owners. Large asset owners and asset managers sit at the top of the investment chain and, therefore, have an

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2 The Economist Intelligence Unit, “The Cost of Inaction: Recognising the Value at Risk from Climate Change,” 2015. Value at risk measures the loss a portfolio may experience, within a given time horizon, at a particular probability, and the stock of manageable assets is defined as the total stock of assets held by non-bank financial institutions. Bank assets were excluded as they are largely managed by banks themselves.

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important role to play in influencing the organizations in which they invest to provide better climate-related financial disclosures.

In developing and finalizing its recommendations, the Task Force solicited input throughout the process. First, in April 2016, the Task Force sought public comment on the scope and high-level objectives of its work. As the Task Force developed its disclosure recommendations, it continued to solicit feedback through hundreds of industry interviews, meetings, and other touchpoints. Then, in December 2016, the Task Force issued its draft recommendations and sought public comment on the recommendations as well as certain key issues, receiving over 300 responses. This final report reflects the Task Force’s consideration of industry and other public feedback received throughout 2016 and 2017. Section E contains a summary of key issues raised by the industry as well as substantive changes to the report since December.

Disclosure in Mainstream Financial Filings
The Task Force recommends that preparers of climate-related financial disclosures provide such disclosures in their mainstream (i.e., public) annual financial filings. In most G20 jurisdictions, companies with public debt or equity have a legal obligation to disclose material information in their financial filings—including material climate-related information. The Task Force believes climate-related issues are or could be material for many organizations, and its recommendations should be useful to organizations in complying more effectively with existing disclosure obligations. In addition, disclosure in mainstream financial filings should foster shareholder engagement and broader use of climate-related financial disclosures, thus promoting a more informed understanding of climate-related risks and opportunities by investors and others. The Task Force also believes that publication of climate-related financial information in mainstream annual financial filings will help ensure that appropriate controls govern the production and disclosure of the required information. More specifically, the Task Force expects the governance processes for these disclosures would be similar to those used for existing public financial disclosures and would likely involve review by the chief financial officer and audit committee, as appropriate.

Importantly, organizations should make financial disclosures in accordance with their national disclosure requirements. If certain elements of the recommendations are incompatible with national disclosure requirements for financial filings, the Task Force encourages organizations to disclose those elements in other official company reports that are issued at least annually, widely distributed and available to investors and others, and subject to internal governance processes that are the same or substantially similar to those used for financial reporting.

Core Elements of Climate-Related Financial Disclosures
The Task Force structured its recommendations around four thematic areas that represent core elements of how organizations operate: governance, strategy, risk management, and metrics and targets (Figure 2, p. v). The four overarching recommendations are supported by recommended disclosures that build out the framework with information that will help investors and others understand how reporting organizations assess climate-related risks and opportunities. In addition, there is guidance to support all organizations in developing climate-related financial disclosures consistent with the recommendations and recommended disclosures. The guidance assists preparers by providing context and suggestions for implementing the recommended disclosures. For the financial sector and certain non-financial sectors, supplemental guidance was developed to highlight important sector-specific considerations and provide a fuller picture of potential climate-related financial impacts in those sectors.

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3 See Appendix 2: Task Force Objectives and Approach for more information.
4 The Task Force encourages organizations where climate-related issues could be material in the future to begin disclosing climate-related financial information outside financial filings to facilitate the incorporation of such information into financial filings once climate-related issues are determined to be material.
5 See Figure 4 on p. 14 for the Task Force’s recommendations and recommended disclosures.
Recommendations of the Task Force on Climate-related Financial Disclosures

Climate-Related Scenarios
One of the Task Force's key recommended disclosures focuses on the resilience of an organization's strategy, taking into consideration different climate-related scenarios, including a 2°C or lower scenario. An organization's disclosure of how its strategies might change to address potential climate-related risks and opportunities is a key step to better understanding the potential implications of climate change on the organization. The Task Force recognizes the use of scenarios in assessing climate-related issues and their potential financial implications is relatively recent and practices will evolve over time, but believes such analysis is important for improving the disclosure of decision-useful, climate-related financial information.

Conclusion
Recognizing that climate-related financial reporting is still evolving, the Task Force's recommendations provide a foundation to improve investors' and others' ability to appropriately assess and price climate-related risk and opportunities. The Task Force's recommendations aim to be ambitious, but also practical for near-term adoption. The Task Force expects to advance the quality of mainstream financial disclosures related to the potential effects of climate change on organizations today and in the future and to increase investor engagement with boards and senior management on climate-related issues.

Improving the quality of climate-related financial disclosures begins with organizations' willingness to adopt the Task Force's recommendations. Organizations already reporting climate-related information under other frameworks may be able to disclose under this framework immediately and are strongly encouraged to do so. Those organizations in early stages of evaluating the impact of climate change on their businesses and strategies can begin by disclosing climate-related issues as they relate to governance, strategy, and risk management practices. The Task Force recognizes the challenges associated with measuring the impact of climate change, but believes that by moving climate-related issues into mainstream annual financial filings, practices and techniques will evolve more rapidly. Improved practices and techniques, including data analytics, should further improve the quality of climate-related financial disclosures and, ultimately, support more appropriate pricing of risks and allocation of capital in the global economy.

6 A 2°C Celsius (2°C) scenario lays out an energy system deployment pathway and an emissions trajectory consistent with limiting the global average temperature increase to 2°C above the pre-industrial average. The Task Force is not recommending organizations use a specific 2°C scenario.
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A Introduction
A Introduction

1. Background

It is widely recognized that continued emission of greenhouse gases will cause further warming of the Earth and that warming above 2°C Celsius (2°C), relative to the pre-industrial period, could lead to catastrophic economic and social consequences. As evidence of the growing recognition of the risks posed by climate change, in December 2015, nearly 200 governments agreed to strengthen the global response to the threat of climate change by “holding the increase in the global average temperature to well below 2°C above pre-industrial levels and to pursue efforts to limit the temperature increase to 1.5°C above pre-industrial levels,” referred to as the Paris Agreement.

The large-scale and long-term nature of the problem makes it uniquely challenging, especially in the context of economic decision making. Moreover, the current understanding of the potential financial risks posed by climate change—to companies, investors, and the financial system as a whole—is still at an early stage.

There is a growing demand for decision-useful, climate-related information by a range of participants in the financial markets. Creditors and investors are increasingly demanding access to risk information that is consistent, comparable, reliable, and clear. There has also been increased focus, especially since the financial crisis of 2007-2008, on the negative impact that weak corporate governance can have on shareholder value, resulting in increased demand for transparency from organizations on their risks and risk management practices, including those related to climate change.

The growing demand for decision-useful, climate-related information has resulted in the development of several climate-related disclosure standards. Many of the existing standards, however, focus on disclosure of climate-related information, such as greenhouse gas (GHG) emissions and other sustainability metrics. Users of such climate-related disclosures commonly cite the lack of information on the financial implications around the climate-related aspects of an organization’s business as a key gap. Users also cite inconsistencies in disclosure practices, a lack of context for information, use of boilerplate, and non-comparable reporting as major obstacles to incorporating climate-related risks and opportunities (collectively referred to as climate-related issues) as considerations in their investment, lending, and insurance underwriting decisions over the medium and long term. In addition, evidence suggests that the lack of consistent information hinders investors and others from considering climate-related issues in their asset valuation and allocation processes.

In general, inadequate information about risks can lead to a mispricing of assets and misallocation of capital and can potentially give rise to concerns about financial stability since markets can be vulnerable to abrupt corrections. Recognizing these concerns, the G20 (Group of 20) Finance Ministers and Central Bank Governors requested that the Financial Stability Board (FSB) “convene public- and private-sector participants to review how the financial sector can take account of climate-related issues.” In response to the G20’s request, the FSB held a meeting of public- and private-sector representatives in September 2015 to consider the implications of climate-related issues for the financial sector. “Participants exchanged views on the existing work of the financial sector, authorities, and standard setters in this area and the challenges they face,

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9 Avery Fellow, “*Investors Demand Climate Risk Disclosure*,” Bloomberg, February 2013.
areas for possible further work, and the possible roles the FSB and others could play in taking that work forward. The discussions continually returned to a common theme: the need for better information.”

In most G20 jurisdictions, companies with public debt or equity have a legal obligation to disclose material risks in their financial reports—including material climate-related risks. However, the absence of a standardized framework for disclosing climate-related financial risks makes it difficult for organizations to determine what information should be included in their filings and how it should be presented. Even when reporting similar climate-related information, disclosures are often difficult to compare due to variances in mandatory and voluntary frameworks. The resulting fragmentation in reporting practices and lack of focus on financial impacts have prevented investors, lenders, insurance underwriters, and other users of disclosures from accessing complete information that can inform their economic decisions. Furthermore, because financial-sector organizations’ disclosures depend, in part, on those from the companies in which they invest or lend, regulators face challenges in using financial-sector organizations’ existing disclosures to determine system-wide exposures to climate-related risks.

In response, the FSB established the industry-led Task Force on Climate-related Financial Disclosures (TCFD or Task Force) in December 2015 to design a set of recommendations for consistent “disclosures that will help financial market participants understand their climate-related risks.”

2. The Task Force’s Remit

The FSB called on the Task Force to develop climate-related disclosures that “could promote more informed investment, credit [or lending], and insurance underwriting decisions” and, in turn, “would enable stakeholders to understand better the concentrations of carbon-related assets in the financial sector and the financial system’s exposures to climate-related risks.” The FSB noted that disclosures by the financial sector in particular would “foster an early assessment of these risks” and “facilitate market discipline.” Such disclosures would also “provide a source of data that can be analyzed at a systemic level, to facilitate authorities’ assessments of the materiality of any risks posed by climate change to the financial sector, and the channels through which this is most likely to be transmitted.”

The FSB also emphasized that “any disclosure recommendations by the Task Force would be voluntary, would need to incorporate the principle of materiality and would need to weigh the balance of costs and benefits.” As a result, in devising a principle-based framework for voluntary disclosure, the Task Force sought to balance the needs of the users of disclosures with the challenges faced by the preparers. The FSB further stated that the Task Force’s climate-related financial disclosure recommendations should not “add to the already well developed body of existing disclosure schemes.” In response, the Task Force drew from existing disclosure frameworks where possible and appropriate.

The FSB also noted the Task Force should determine whether the target audience of users of climate-related financial disclosures should extend beyond investors, lenders, and insurance underwriters. Investors, lenders, and insurance underwriters (“primary users”) are the appropriate target audience. These primary users assume the financial risk and reward of the climate-related risks.
decisions they make. The Task Force recognizes that many other organizations, including credit rating agencies, equity analysts, stock exchanges, investment consultants, and proxy advisors also use climate-related financial disclosures, allowing them to push information through the credit and investment chain and contribute to the better pricing of risks by investors, lenders, and insurance underwriters. These organizations, in principle, depend on the same types of information as primary users.

This report presents the Task Force’s recommendations for climate-related financial disclosures and includes supporting information on climate-related risks and opportunities, scenario analysis, and industry feedback that the Task Force considered in developing and then finalizing its recommendations. In addition, the Task Force developed a “stand-alone” document—Implementing the Recommendations of the Task Force on Climate-related Financial Disclosures (Annex)—for organizations to use when preparing disclosures consistent with the recommendations. The Annex provides supplemental guidance for the financial sector as well as for non-financial groups potentially most affected by climate change and the transition to a lower-carbon economy. The supplemental guidance assists preparers by providing additional context and suggestions for implementing the recommended disclosures.

The Task Force’s recommendations provide a foundation for climate-related financial disclosures and aim to be ambitious, but also practical for near-term adoption. The Task Force expects that reporting of climate-related risks and opportunities will evolve over time as organizations, investors, and others contribute to the quality and consistency of the information disclosed.

**Box 1**

**Task Force on Climate-related Financial Disclosures**

The Task Force membership, first announced on January 21, 2016, has international representation and spans various types of organizations, including banks, insurance companies, asset managers, pension funds, large non-financial companies, accounting and consulting firms, and credit rating agencies—a unique collaborative partnership between the users and preparers of financial reports.

In its work, the Task Force drew on its members’ expertise, stakeholder engagement, and existing climate-related disclosure regimes to develop a singular, accessible framework for climate-related financial disclosure. See Appendix 1 for a list of the Task Force members and Appendix 2 for more information on the Task Force’s approach.

The Task Force is comprised of 32 global members representing a broad range of economic sectors and financial markets and a careful balance of users and preparers of climate-related financial disclosures.

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**Appendix B**

**Attachment One**

Climate and Resiliency (EX) Task Force

4/9/21

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33
B Climate-Related Risks, Opportunities, and Financial Impacts
B Climate-Related Risks, Opportunities, and Financial Impacts

Through its work, the Task Force identified a growing demand by investors, lenders, insurance underwriters, and other stakeholders for decision-useful, climate-related financial information. Improved disclosure of climate-related risks and opportunities will provide investors, lenders, insurance underwriters, and other stakeholders with the metrics and information needed to undertake robust and consistent analyses of the potential financial impacts of climate change.

The Task Force found that while several climate-related disclosure frameworks have emerged across different jurisdictions in an effort to meet the growing demand for such information, there is a need for a standardized framework to promote alignment across existing regimes and G20 jurisdictions and to provide a common framework for climate-related financial disclosures. An important element of such a framework is the consistent categorization of climate-related risks and opportunities. As a result, the Task Force defined categories for climate-related risks and climate-related opportunities. The Task Force's recommendations serve to encourage organizations to evaluate and disclose, as part of their annual financial filing preparation and reporting processes, the climate-related risks and opportunities that are most pertinent to their business activities. The main climate-related risks and opportunities that organizations should consider are described below and in Tables 1 and 2 (pp. 10-11).

1. Climate-Related Risks

   a. Transition Risks

   Transitioning to a lower-carbon economy may entail extensive policy, legal, technology, and market changes to address mitigation and adaptation requirements related to climate change. Depending on the nature, speed, and focus of these changes, transition risks may pose varying levels of financial and reputational risk to organizations.

   Policy and Legal Risks

   Policy actions around climate change continue to evolve. Their objectives generally fall into two categories—policy actions that attempt to constrain actions that contribute to the adverse effects of climate change or policy actions that seek to promote adaptation to climate change. Some examples include implementing carbon-pricing mechanisms to reduce GHG emissions, shifting energy use toward lower emission sources, adopting energy-efficiency solutions, encouraging greater water efficiency measures, and promoting more sustainable land-use practices. The risk associated with and financial impact of policy changes depend on the nature and timing of the policy change.21

   Another important risk is litigation or legal risk. Recent years have seen an increase in climate-related litigation claims being brought before the courts by property owners, municipalities, states, insurers, shareholders, and public interest organizations.22 Reasons for such litigation include the failure of organizations to mitigate impacts of climate change, failure to adapt to climate change, and the insufficiency of disclosure around material financial risks. As the value of loss and damage arising from climate change grows, litigation risk is also likely to increase.

21 Organizations should assess not only the potential direct effects of policy actions on their operations, but also the potential second and third order effects on their supply and distribution chains.

Technology Risk
Technological improvements or innovations that support the transition to a lower-carbon, energy-efficient economic system can have a significant impact on organizations. For example, the development and use of emerging technologies such as renewable energy, battery storage, energy efficiency, and carbon capture and storage will affect the competitiveness of certain organizations, their production and distribution costs, and ultimately the demand for their products and services from end users. To the extent that new technology displaces old systems and disrupts some parts of the existing economic system, winners and losers will emerge from this “creative destruction” process. The timing of technology development and deployment, however, is a key uncertainty in assessing technology risk.

Market Risk
While the ways in which markets could be affected by climate change are varied and complex, one of the major ways is through shifts in supply and demand for certain commodities, products, and services as climate-related risks and opportunities are increasingly taken into account.

Reputation Risk
Climate change has been identified as a potential source of reputational risk tied to changing customer or community perceptions of an organization’s contribution to or detraction from the transition to a lower-carbon economy.

b. Physical Risks
Physical risks resulting from climate change can be event driven (acute) or longer-term shifts (chronic) in climate patterns. Physical risks may have financial implications for organizations, such as direct damage to assets and indirect impacts from supply chain disruption. Organizations’ financial performance may also be affected by changes in water availability, sourcing, and quality; food security; and extreme temperature changes affecting organizations’ premises, operations, supply chain, transport needs, and employee safety.

Acute Risk
Acute physical risks refer to those that are event-driven, including increased severity of extreme weather events, such as cyclones, hurricanes, or floods.

Chronic Risk
Chronic physical risks refer to longer-term shifts in climate patterns (e.g., sustained higher temperatures) that may cause sea level rise or chronic heat waves.

2. Climate-Related Opportunities
Efforts to mitigate and adapt to climate change also produce opportunities for organizations, for example, through resource efficiency and cost savings, the adoption of low-emission energy sources, the development of new products and services, access to new markets, and building resilience along the supply chain. Climate-related opportunities will vary depending on the region, market, and industry in which an organization operates. The Task Force identified several areas of opportunity as described below.

a. Resource Efficiency
There is growing evidence and examples of organizations that have successfully reduced operating costs by improving efficiency across their production and distribution processes, buildings, machinery/appliances, and transport/mobility—in particular in relation to energy efficiency but also including broader materials, water, and waste management.23 Such actions can

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result in direct cost savings to organizations’ operations over the medium to long term and contribute to the global efforts to curb emissions. Innovation in technology is assisting this transition; such innovation includes developing efficient heating solutions and circular economy solutions, making advances in LED lighting technology and industrial motor technology, retrofitting buildings, employing geothermal power, offering water usage and treatment solutions, and developing electric vehicles.

b. Energy Source
According to the International Energy Agency (IEA), to meet global emission-reduction goals, countries will need to transition a major percentage of their energy generation to low emission alternatives such as wind, solar, wave, tidal, hydro, geothermal, nuclear, biofuels, and carbon capture and storage. For the fifth year in a row, investments in renewable energy capacity have exceeded investments in fossil fuel generation. The trend toward decentralized clean energy sources, rapidly declining costs, improved storage capabilities, and subsequent global adoption of these technologies are significant. Organizations that shift their energy usage toward low emission energy sources could potentially save on annual energy costs.

c. Products and Services
Organizations that innovate and develop new low-emission products and services may improve their competitive position and capitalize on shifting consumer and producer preferences. Some examples include consumer goods and services that place greater emphasis on a product’s carbon footprint in its marketing and labeling (e.g., travel, food, beverage and consumer staples, mobility, printing, fashion, and recycling services) and producer goods that place emphasis on reducing emissions (e.g., adoption of energy-efficiency measures along the supply chain).

d. Markets
Organizations that pro-actively seek opportunities in new markets or types of assets may be able to diversify their activities and better position themselves for the transition to a lower-carbon economy. In particular, opportunities exist for organizations to access new markets through collaborating with governments, development banks, small-scale local entrepreneurs, and community groups in developed and developing countries as they work to shift to a lower-carbon economy. New opportunities can also be captured through underwriting or financing green bonds and infrastructure (e.g., low-emission energy production, energy efficiency, grid connectivity, or transport networks).

e. Resilience
The concept of climate resilience involves organizations developing adaptive capacity to respond to climate change to better manage the associated risks and seize opportunities, including the ability to respond to transition risks and physical risks. Opportunities include improving efficiency, designing new production processes, and developing new products. Opportunities related to resilience may be especially relevant for organizations with long-lived fixed assets or extensive supply or distribution networks; those that depend critically on utility and infrastructure networks or natural resources in their value chain; and those that may require longer-term financing and investment.

25 As described by Pearce and Turner, circular economy refers to a system in which resource input and waste, emission, and energy leakage are minimized. This can be achieved through long-lasting design, maintenance, repair, reuse, remanufacturing, refurbishing, and recycling. This is in contrast to a linear economy which is a “take, make, dispose” model of production.
26 IEA, “Global energy investment down 8% in 2015 with flows signaling move towards cleaner energy.” September 14, 2016.
28 Ceres, “Power Forward 3.0: How the largest US companies are capturing business value while addressing climate change,” 2017.
3. Financial Impacts

Better disclosure of the financial impacts of climate-related risks and opportunities on an organization is a key goal of the Task Force's work. In order to make more informed financial decisions, investors, lenders, and insurance underwriters need to understand how climate-related risks and opportunities are likely to impact an organization's future financial position as reflected in its income statement, cash flow statement, and balance sheet as outlined in Figure 1. While climate change affects nearly all economic sectors, the level and type of exposure and the impact of climate-related risks differs by sector, industry, geography, and organization.30

Fundamentally, the financial impacts of climate-related issues on an organization are driven by the specific climate-related risks and opportunities to which the organization is exposed and its strategic and risk management decisions on managing those risks (i.e., mitigate, transfer, accept, or control) and seizing those opportunities. The Task Force has identified four major categories, described in Figure 2 (p. 9), through which climate-related risks and opportunities may affect an organization's current and future financial positions.

The financial impacts of climate-related issues on organizations are not always clear or direct, and, for many organizations, identifying the issues, assessing potential impacts, and ensuring material issues are reflected in financial filings may be challenging. Key reasons for this are likely because of (1) limited knowledge of climate-related issues within organizations; (2) the tendency to focus mainly on near-term risks without paying adequate attention to risks that may arise in the longer term; and (3) the difficulty in quantifying the financial effects of climate-related issues.31 To assist organizations in identifying climate-related issues and their impacts, the Task Force developed Table 1 (p. 10), which provides examples of climate-related risks and their potential financial impacts, and Table 2 (p. 11), which provides examples of climate-related opportunities and their potential financial impacts. In addition, Section A.4 in the Annex provides more information on the major categories of financial impacts—revenues, expenditures, assets and liabilities, and capital and financing—that are likely to be most relevant for specific industries.

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30 SASB research demonstrates that 72 out of 79 Sustainable Industry Classification System (SICS™) industries are significantly affected in some way by climate-related risk.

The Task Force encourages organizations to undertake both historical and forward-looking analyses when considering the potential financial impacts of climate change, with greater focus on forward-looking analyses as the efforts to mitigate and adapt to climate change are without historical precedent. This is one of the reasons the Task Force believes scenario analysis is important for organizations to consider incorporating into their strategic planning or risk management practices.
Table 1

**Examples of Climate-Related Risks and Potential Financial Impacts**

<table>
<thead>
<tr>
<th>Type</th>
<th>Climate-Related Risks</th>
<th>Potential Financial Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy and Legal</strong></td>
<td>- Increased pricing of GHG emissions</td>
<td>- Increased operating costs (e.g., higher compliance costs, increased insurance premiums)</td>
</tr>
<tr>
<td></td>
<td>- Enhanced emissions-reporting obligations</td>
<td>- Write-offs, asset impairment, and early retirement of existing assets due to policy changes</td>
</tr>
<tr>
<td></td>
<td>- Mandates on and regulation of existing</td>
<td>- Increased costs and/or reduced demand for products and services resulting from fines and judgments</td>
</tr>
<tr>
<td></td>
<td>products and services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Exposure to litigation</td>
<td></td>
</tr>
<tr>
<td><strong>Technology</strong></td>
<td>- Substitution of existing products</td>
<td>- Write-offs and early retirement of existing assets</td>
</tr>
<tr>
<td></td>
<td>and services with lower emissions options</td>
<td>- Reduced demand for products and services</td>
</tr>
<tr>
<td></td>
<td>- Unsuccessful investment in new</td>
<td>- Research and development (R&amp;D) expenditures in new and alternative technologies</td>
</tr>
<tr>
<td></td>
<td>technologies</td>
<td>- Capital investments in technology development</td>
</tr>
<tr>
<td></td>
<td>- Costs to transition to lower</td>
<td>- Costs to adopt/deploy new practices and processes</td>
</tr>
<tr>
<td></td>
<td>emissions technology</td>
<td></td>
</tr>
<tr>
<td><strong>Market</strong></td>
<td>- Changing customer behavior</td>
<td>- Reduced demand for goods and services due to shift in consumer preferences</td>
</tr>
<tr>
<td></td>
<td>- Uncertainty in market signals</td>
<td>- Increased production costs due to changing input prices (e.g., energy, water) and output requirements (e.g., waste treatment)</td>
</tr>
<tr>
<td></td>
<td>- Increased cost of raw materials</td>
<td>- Abrupt and unexpected shifts in energy costs</td>
</tr>
<tr>
<td><strong>Reputation</strong></td>
<td>- Shifts in consumer preferences</td>
<td>- Change in revenue mix and sources, resulting in decreased revenues</td>
</tr>
<tr>
<td></td>
<td>- Stigmatization of sector</td>
<td>- Re-pricing of assets (e.g., fossil fuel reserves, land valuations, securities valuations)</td>
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<tr>
<td></td>
<td>- Increased stakeholder concern or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>negative stakeholder feedback</td>
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</tr>
<tr>
<td><strong>Acute</strong></td>
<td>- Increased severity of extreme</td>
<td>- Reduced revenue from decreased demand for goods/services</td>
</tr>
<tr>
<td></td>
<td>weather events such as cyclones and</td>
<td>- Reduced revenue from decreased production capacity (e.g., delayed planning approvals, supply chain interruptions)</td>
</tr>
<tr>
<td></td>
<td>floods</td>
<td>- Reduced revenue from negative impacts on workforce (e.g., health, safety, absenteeism)</td>
</tr>
<tr>
<td><strong>Physical Risks</strong></td>
<td>- Changes in precipitation patterns and</td>
<td>- Reduced revenue from negative impacts on workforce (e.g., damage to property and assets in “high-risk” locations)</td>
</tr>
<tr>
<td></td>
<td>extreme variability in weather patterns</td>
<td>- Increased operating costs (e.g., inadequate water supply for hydroelectric plants or to cool nuclear and fossil fuel plants)</td>
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<tr>
<td></td>
<td>- Rising mean temperatures</td>
<td>- Increased capital costs (e.g., damage to facilities)</td>
</tr>
<tr>
<td></td>
<td>- Rising sea levels</td>
<td>- Reduced revenues from lower sales/output</td>
</tr>
<tr>
<td></td>
<td><strong>Chronic</strong></td>
<td>- Increased insurance premiums and potential for reduced availability of insurance on assets in “high-risk” locations</td>
</tr>
</tbody>
</table>

22 The sub-category risks described under each major category are not mutually exclusive, and some overlap exists.
Table 2
Examples of Climate-Related Opportunities and Potential Financial Impacts

<table>
<thead>
<tr>
<th>Type</th>
<th>Climate-Related Opportunities</th>
<th>Potential Financial Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource Efficiency</td>
<td>Use of more efficient modes of transport</td>
<td>Reduced operating costs (e.g., through efficiency gains and cost reductions)</td>
</tr>
<tr>
<td></td>
<td>Use of more efficient production and distribution processes</td>
<td>Increased production capacity, resulting in increased revenues</td>
</tr>
<tr>
<td></td>
<td>Use of recycling</td>
<td>Increased value of fixed assets (e.g., highly rated energy-efficient buildings)</td>
</tr>
<tr>
<td></td>
<td>Move to more efficient buildings</td>
<td>Benefits to workforce management and planning (e.g., improved health and safety, employee satisfaction) resulting in lower costs</td>
</tr>
<tr>
<td></td>
<td>Reduced water usage and consumption</td>
<td></td>
</tr>
<tr>
<td>Energy Source</td>
<td>Use of lower-emission sources of energy</td>
<td>Reduced operational costs (e.g., through use of lowest cost abatement)</td>
</tr>
<tr>
<td></td>
<td>Use of supportive policy incentives</td>
<td>Reduced exposure to future fossil fuel price increases</td>
</tr>
<tr>
<td></td>
<td>Use of new technologies</td>
<td>Reduced exposure to GHG emissions and therefore less sensitivity to changes in cost of carbon</td>
</tr>
<tr>
<td></td>
<td>Participation in carbon market</td>
<td>Returns on investment in low-emission technology</td>
</tr>
<tr>
<td></td>
<td>Shift toward decentralized energy generation</td>
<td>Increased capital availability (e.g., as more investors favor lower-emissions producers)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reputational benefits resulting in increased demand for goods/services</td>
</tr>
<tr>
<td>Products and Services</td>
<td>Development and/or expansion of low emission goods and services</td>
<td>Increased revenue through demand for lower emissions products and services</td>
</tr>
<tr>
<td></td>
<td>Development of climate adaptation and insurance risk solutions</td>
<td>Increased revenue through new solutions to adaptation needs (e.g., insurance risk transfer products and services)</td>
</tr>
<tr>
<td></td>
<td>Development of new products or services through R&amp;D and innovation</td>
<td>Better competitive position to reflect shifting consumer preferences, resulting in increased revenues</td>
</tr>
<tr>
<td></td>
<td>Ability to diversify business activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shift in consumer preferences</td>
<td></td>
</tr>
<tr>
<td>Markets</td>
<td>Access to new markets</td>
<td>Increased revenues through access to new and emerging markets (e.g., partnerships with governments, development banks)</td>
</tr>
<tr>
<td></td>
<td>Use of public-sector incentives</td>
<td>Increased diversification of financial assets (e.g., green bonds and infrastructure)</td>
</tr>
<tr>
<td></td>
<td>Access to new assets and locations needing insurance coverage</td>
<td></td>
</tr>
<tr>
<td>Resilience</td>
<td>Participation in renewable energy programs and adoption of energy-efficiency measures</td>
<td>Increased market valuation through resilience planning (e.g., infrastructure, land, buildings)</td>
</tr>
<tr>
<td></td>
<td>Resource substitutes/diversification</td>
<td>Increased reliability of supply chain and ability to operate under various conditions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increased revenue through new products and services related to ensuring resiliency</td>
</tr>
</tbody>
</table>

33 The opportunity categories are not mutually exclusive, and some overlap exists.

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C Recommendations and Guidance
C  Recommendations and Guidance

1. Overview of Recommendations and Guidance

To fulfill its remit, the Task Force developed four widely adoptable recommendations on climate-related financial disclosures applicable to organizations across sectors and jurisdictions. In developing its recommendations, the Task Force considered the challenges for preparers of disclosures as well as the benefits of such disclosures to investors, lenders, and insurance underwriters. To achieve this balance, the Task Force engaged in significant outreach and consultation with users and preparers of disclosures and drew upon existing climate-related disclosure regimes. The insights gained from the outreach and consultations directly informed the development of the recommendations.

The Task Force structured its recommendations around four thematic areas that represent core elements of how organizations operate—governance, strategy, risk management, and metrics and targets. The four overarching recommendations are supported by key climate-related financial disclosures—referred to as recommended disclosures—that build out the framework with information that will help investors and others understand how reporting organizations think about and assess climate-related risks and opportunities. In addition, there is guidance to support all organizations in developing climate-related financial disclosures consistent with the recommendations and recommended disclosures as well as supplemental guidance for specific sectors. The structure is depicted in Figure 3 below, and the Task Force’s recommendations and supporting recommended disclosures are presented in Figure 4 (p. 14).

The Task Force’s supplemental guidance is included in the Annex and covers the financial sector as well as non-financial industries potentially most affected by climate change and the transition to a lower-carbon economy (referred to as non-financial groups). The supplemental guidance provides these preparers with additional context and suggestions for implementing the recommended disclosures and should be used in conjunction with the guidance for all sectors.
## Recommendations and Supporting Recommended Disclosures

**Governance**

Disclose the organization’s governance around climate-related risks and opportunities.

<table>
<thead>
<tr>
<th>Recommended Disclosures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Describe the board’s oversight of climate-related risks and opportunities.</td>
</tr>
<tr>
<td>b) Describe management’s role in assessing and managing climate-related risks and opportunities.</td>
</tr>
<tr>
<td>c) Describe the resilience of the organization’s strategy, taking into consideration different climate-related scenarios, including a 2°C or lower scenario.</td>
</tr>
</tbody>
</table>

**Strategy**

Disclose the actual and potential impacts of climate-related risks and opportunities on the organization’s businesses, strategy, and financial planning where such information is material.

<table>
<thead>
<tr>
<th>Recommended Disclosures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Describe the climate-related risks and opportunities the organization has identified over the short, medium, and long term.</td>
</tr>
<tr>
<td>b) Describe the impact of climate-related risks and opportunities on the organization’s businesses, strategy, and financial planning.</td>
</tr>
<tr>
<td>c) Describe how processes for identifying, assessing, and managing climate-related risks and opportunities are integrated into the organization’s overall risk management.</td>
</tr>
</tbody>
</table>

**Risk Management**

Disclose how the organization identifies, assesses, and manages climate-related risks.

<table>
<thead>
<tr>
<th>Recommended Disclosures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Describe the organization’s processes for identifying and assessing climate-related risks.</td>
</tr>
<tr>
<td>b) Describe the organization’s processes for managing climate-related risks.</td>
</tr>
<tr>
<td>c) Describe how processes for identifying, assessing, and managing climate-related risks are integrated into the organization’s overall risk management.</td>
</tr>
</tbody>
</table>

**Metrics and Targets**

Disclose the metrics and targets used to assess and manage relevant climate-related risks and opportunities where such information is material.

<table>
<thead>
<tr>
<th>Recommended Disclosures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Disclose the metrics used by the organization to assess climate-related risks and opportunities in line with its strategy and risk management process.</td>
</tr>
<tr>
<td>b) Disclose Scope 1, Scope 2, and, if appropriate, Scope 3 greenhouse gas (GHG) emissions, and the related risks.</td>
</tr>
<tr>
<td>c) Describe the targets used by the organization to manage climate-related risks and opportunities and performance against targets.</td>
</tr>
</tbody>
</table>
Figure 5 provides a mapping of the recommendations (governance, strategy, risk management, and metrics and targets) and recommended disclosures (a, b, c) for which supplemental guidance was developed for the financial sector and non-financial groups.

- **Financial Sector.** The Task Force developed supplemental guidance for the financial sector, which it organized into four major industries largely based on activities performed. The four industries are banks (lending), insurance companies (underwriting), asset managers (asset management), and asset owners, which include public- and private-sector pension plans, endowments, and foundations (investing). The Task Force believes that disclosures by the financial sector could foster an early assessment of climate-related risks and opportunities, improve pricing of climate-related risks, and lead to more informed capital allocation decisions.

- **Non-Financial Groups.** The Task Force developed supplemental guidance for non-financial industries that account for the largest proportion of GHG emissions, energy usage, and water usage. These industries were organized into four groups (i.e., non-financial groups)—Energy; Materials and Buildings; Transportation; and Agriculture, Food, and Forest Products—based on similarities in climate-related risks as shown in Box 2 (p. 16). While this supplemental guidance focuses on a subset of non-financial industries, organizations in other industries with similar business activities may wish to review and consider the issues and topics contained in the supplemental guidance.

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34 The use of the term “insurance companies” in this report includes re-insurers.
Box 2

Determination of Non-Financial Groups

In an effort to focus supplemental guidance on those non-financial sectors and industries with the highest likelihood of climate-related financial impacts, the Task Force assessed three factors most likely to be affected by both transition risk (policy and legal, technology, market, and reputation) and physical risk (acute and chronic)—GHG emissions, energy usage, and water usage.

The underlying premise in using these three factors is that climate-related physical and transition risks will likely manifest themselves primarily and broadly in the form of constraints on GHG emissions, effects on energy production and usage, and effects on water availability, usage, and quality. Other factors, such as waste management and land use, are also important, but may not be as determinative across a wide range of industries or may be captured in one of the primary categories.

In taking this approach, the Task Force consulted a number of sources regarding the ranking of various sectors and industries according to these three factors. The various rankings were used to determine an overall set of sectors and industries that have significant exposure to transition or physical risks related to GHG emissions, energy, or water. The sectors and industries were grouped into four categories of industries that have similar economic activities and climate-related exposures.

These four groups and their associated industries are intended to be indicative of the economic activities associated with these industries rather than definitive industry categories. Other industries with similar activities and climate-related exposures should consider the supplemental guidance as well.

The Task Force validated its approach using a variety of sources, including:

1. The TCFD Phase I report public consultation, soliciting more than 200 responses which ranked Energy, Utilities, Materials, Industrials and Consumer Staples/Discretionary, in that order, as the Global Industry Classification Standard (GICS) sectors most important for disclosure guidelines to cover.

2. Numerous sector-specific disclosure guidance documents to understand various breakdowns by economic activity, sector, and industries, including from the following sources: CDP, GHG Protocol, Global Real Estate Sustainability Benchmark (GRESB), Global Reporting Initiative (GRI), Institutional Investors Group on Climate Change (IIGCC), IPIECA (the global oil and gas industry association for environmental and social issues), and the Sustainability Accounting Standards Board (SASB).

3. The Intergovernmental Panel on Climate Change (IPCC) report “Climate Change 2014 – Mitigation of Climate Change” that provides an analysis of global direct and indirect emissions by economic sector. The IPCC analysis highlights the dominant emissions-producing sectors as Energy; Industry; Agriculture, Forestry, and Other Land Use; and Transportation and Buildings (Commercial and Residential).

4. Research and documentation from non-governmental organizations (NGOs) and industry organizations that provide information on which industries have the highest exposures to climate change, including those from Cambridge Institute of Sustainability Leadership, China's National Development and Reform Commission (NDRC), Environmental Resources Management (ERM), IEA, Moody’s, S&P Global Ratings, and WRI/UNEPFI.

Based on its assessment, the Task Force identified the four groups and their associated industries, listed in the table below, as those that would most benefit from supplemental guidance.

<table>
<thead>
<tr>
<th>Energy</th>
<th>Transportation</th>
<th>Materials and Buildings</th>
<th>Agriculture, Food, and Forest Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oil and Gas</td>
<td>Air Freight</td>
<td>Metals and Mining</td>
<td>Beverages</td>
</tr>
<tr>
<td>Coal</td>
<td>Passenger Air Transportation</td>
<td>Chemicals</td>
<td>Agriculture</td>
</tr>
<tr>
<td>Electric Utilities</td>
<td>Maritime Transportation</td>
<td>Construction Materials</td>
<td>Packaged Foods and Meats</td>
</tr>
<tr>
<td></td>
<td>Rail Transportation</td>
<td>Capital Goods</td>
<td>Paper and Forest Products</td>
</tr>
<tr>
<td></td>
<td>Trucking Services</td>
<td>Real Estate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Automobiles and Components</td>
<td>Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>and Development</td>
<td></td>
</tr>
</tbody>
</table>

**Recommendations of the Task Force on Climate-related Financial Disclosures**

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2. Implementing the Recommendations

a. Scope of Coverage
To promote more informed investing, lending, and insurance underwriting decisions, the Task Force recommends all organizations with public debt or equity implement its recommendations. Because climate-related issues are relevant for other types of organizations as well, the Task Force encourages all organizations to implement these recommendations. In particular, the Task Force believes that asset managers and asset owners, including public- and private-sector pension plans, endowments, and foundations, should implement its recommendations so that their clients and beneficiaries may better understand the performance of their assets, consider the risks of their investments, and make more informed investment choices.

b. Location of Disclosures and Materiality
The Task Force recommends that organizations provide climate-related financial disclosures in their mainstream (i.e., public) annual financial filings.35 In most G20 jurisdictions, public companies have a legal obligation to disclose material information in their financial filings—including material climate-related information; and the Task Force's recommendations are intended to help organizations meet existing disclosure obligations more effectively.36 The Task Force's recommendations were developed to apply broadly across sectors and jurisdictions and should not be seen as superseding national disclosure requirements. Importantly, organizations should make financial disclosures in accordance with their national disclosure requirements. If certain elements of the recommendations are incompatible with national disclosure requirements for financial filings, the Task Force encourages organizations to disclose those elements in other official company reports that are issued at least annually, widely distributed and available to investors and others, and subject to internal governance processes that are the same or substantially similar to those used for financial reporting.

The Task Force recognizes that most information included in financial filings is subject to a materiality assessment. However, because climate-related risk is a non-diversifiable risk that affects nearly all industries, many investors believe it requires special attention. For example, in assessing organizations’ financial and operating results, many investors want insight into the governance and risk management context in which such results are achieved. The Task Force believes disclosures related to its Governance and Risk Management recommendations directly address this need for context and should be included in annual financial filings.

For disclosures related to the Strategy and Metrics and Targets recommendations, the Task Force believes organizations should provide such information in annual financial filings when the information is deemed material. Certain organizations—those in the four non-financial groups that have more than one billion U.S. dollar equivalent (USDE) in annual revenue—should consider disclosing such information in other reports when the information is not deemed material and not included in financial filings.37 Because these organizations are more likely than others to be financially impacted over time, investors are interested in monitoring how these organizations’ strategies evolve.

35 Financial filings refer to the annual reporting packages in which organizations are required to deliver their audited financial results under the corporate, compliance, or securities laws of the jurisdictions in which they operate. While reporting requirements differ internationally, financial filings generally contain financial statements and other information such as governance statements and management commentary.
36 The Task Force encourages organizations where climate-related issues could be material in the future to begin disclosing climate-related financial information outside financial filings to facilitate the incorporation of such information into financial filings once climate-related issues are determined to be material.
37 The Task Force chose a one billion USDE annual revenue threshold because it captures organizations responsible for over 90 percent of Scope 1 and 2 GHG emissions in the industries represented by the four non-financial groups (about 2,250 organizations out of roughly 15,000).
The Task Force recognizes reporting by asset managers and asset owners is intended to satisfy the needs of clients, beneficiaries, regulators, and oversight bodies and follows a format that is generally different from corporate financial reporting. For purposes of adopting the Task Force's recommendations, asset managers and asset owners should use their existing means of financial reporting to their clients and beneficiaries where relevant and where feasible. Likewise, asset managers and asset owners should consider materiality in the context of their respective mandates and investment performance for clients and beneficiaries.

The Task Force believes that climate-related financial disclosures should be subject to appropriate internal governance processes. Since these disclosures should be included in annual financial filings, the governance processes should be similar to those used for existing financial reporting and would likely involve review by the chief financial officer and audit committee, as appropriate. The Task Force recognizes that some organizations may provide some or all of their climate-related financial disclosures in reports other than financial filings. This may occur because the organizations are not required to issue public financial reports (e.g., some asset managers and asset owners). In such situations, organizations should follow internal governance processes that are the same or substantially similar to those used for financial reporting.

c. Principles for Effective Disclosures
To underpin its recommendations and help guide current and future developments in climate-related financial reporting, the Task Force developed seven principles for effective disclosure (Figure 6), which are described more fully in Appendix 3. When used by organizations in preparing their climate-related financial disclosures, these principles can help achieve high-quality and decision-useful disclosures that enable users to understand the impact of climate change on organizations. The Task Force encourages organizations to consider these principles as they develop climate-related financial disclosures.

The Task Force's disclosure principles are largely consistent with internationally accepted frameworks for financial reporting and are generally applicable to most providers of financial disclosures. The principles are designed to assist organizations in making clear the linkages between climate-related issues and their governance, strategy, risk management, and metrics and targets.

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38 The Task Force recommends asset managers and asset owners include carbon footprinting information in their reporting to clients and beneficiaries, as described in Section D of the Annex, to support the assessment and management of climate-related risks.
3. Guidance for All Sectors

The Task Force has developed guidance to support all organizations in developing climate-related financial disclosures consistent with its recommendations and recommended disclosures. The guidance assists preparers by providing context and suggestions for implementing the recommended disclosures. Recognizing organizations have differing levels of capacity to disclose under the recommendations, the guidance provides descriptions of the types of information that should be disclosed or considered.

a. Governance

Investors, lenders, insurance underwriters, and other users of climate-related financial disclosures (collectively referred to as “investors and other stakeholders”) are interested in understanding the role an organization’s board plays in overseeing climate-related issues as well as management’s role in assessing and managing those issues. Such information supports evaluations of whether climate-related issues receive appropriate board and management attention.

Governance

Disclose the organization’s governance around climate-related risks and opportunities.

<table>
<thead>
<tr>
<th>Recommended Disclosure a)</th>
<th>Guidance for All Sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe the board’s oversight of climate-related risks and opportunities.</td>
<td>In describing the board’s oversight of climate-related issues, organizations should consider including a discussion of the following:</td>
</tr>
<tr>
<td></td>
<td>– processes and frequency by which the board and/or board committees (e.g., audit, risk, or other committees) are informed about climate-related issues,</td>
</tr>
<tr>
<td></td>
<td>– whether the board and/or board committees consider climate-related issues when reviewing and guiding strategy, major plans of action, risk management policies, annual budgets, and business plans as well as setting the organization’s performance objectives, monitoring implementation and performance, and overseeing major capital expenditures, acquisitions, and divestitures, and</td>
</tr>
<tr>
<td></td>
<td>– how the board monitors and oversees progress against goals and targets for addressing climate-related issues.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommended Disclosure b)</th>
<th>Guidance for All Sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe management’s role in assessing and managing climate-related risks and opportunities.</td>
<td>In describing management’s role related to the assessment and management of climate-related issues, organizations should consider including the following information:</td>
</tr>
<tr>
<td></td>
<td>– whether the organization has assigned climate-related responsibilities to management-level positions or committees; and, if so, whether such management positions or committees report to the board or a committee of the board and whether those responsibilities include assessing and/or managing climate-related issues,</td>
</tr>
<tr>
<td></td>
<td>– a description of the associated organizational structure(s),</td>
</tr>
<tr>
<td></td>
<td>– processes by which management is informed about climate-related issues, and</td>
</tr>
<tr>
<td></td>
<td>– how management (through specific positions and/or management committees) monitors climate-related issues.</td>
</tr>
</tbody>
</table>
b. Strategy
Investors and other stakeholders need to understand how climate-related issues may affect an organization's businesses, strategy, and financial planning over the short, medium, and long term. Such information is used to inform expectations about the future performance of an organization.

**Strategy**

Disclose the actual and potential impacts of climate-related risks and opportunities on the organization's businesses, strategy, and financial planning where such information is material.

<table>
<thead>
<tr>
<th>Recommended Disclosure a)</th>
<th>Guidance for All Sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe the climate-related risks and opportunities the organization has identified over the short, medium, and long term.</td>
<td>Organizations should provide the following information:</td>
</tr>
<tr>
<td></td>
<td>– a description of what they consider to be the relevant short-, medium-, and long-term time horizons, taking into consideration the useful life of the organization's assets or infrastructure and the fact that climate-related issues often manifest themselves over the medium and longer terms,</td>
</tr>
<tr>
<td></td>
<td>– a description of the specific climate-related issues for each time horizon (short, medium, and long term) that could have a material financial impact on the organization, and</td>
</tr>
<tr>
<td></td>
<td>– a description of the process(es) used to determine which risks and opportunities could have a material financial impact on the organization.</td>
</tr>
</tbody>
</table>

Organizations should consider providing a description of their risks and opportunities by sector and/or geography, as appropriate. In describing climate-related issues, organizations should refer to Tables 1 and 2 (pp. 10-11).

<table>
<thead>
<tr>
<th>Recommended Disclosure b)</th>
<th>Guidance for All Sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe the impact of climate-related risks and opportunities on the organization's businesses, strategy, and financial planning.</td>
<td>Building on recommended disclosure (a), organizations should discuss how identified climate-related issues have affected their businesses, strategy, and financial planning.</td>
</tr>
<tr>
<td></td>
<td>Organizations should consider including the impact on their businesses and strategy in the following areas:</td>
</tr>
<tr>
<td></td>
<td>– Products and services</td>
</tr>
<tr>
<td></td>
<td>– Supply chain and/or value chain</td>
</tr>
<tr>
<td></td>
<td>– Adaptation and mitigation activities</td>
</tr>
<tr>
<td></td>
<td>– Investment in research and development</td>
</tr>
<tr>
<td></td>
<td>– Operations (including types of operations and location of facilities)</td>
</tr>
</tbody>
</table>

Organizations should describe how climate-related issues serve as an input to their financial planning process, the time period(s) used, and how these risks and opportunities are prioritized. Organizations' disclosures should reflect a holistic picture of the interdependencies among the factors that affect their ability to create value over time. Organizations should also consider including in their disclosures the impact on financial planning in the following areas:

|                           | Operating costs and revenues |
|                           | Capital expenditures and capital allocation |
|                           | Acquisitions or divestments |
|                           | Access to capital |

If climate-related scenarios were used to inform the organization's strategy and financial planning, such scenarios should be described.
### Strategy

Disclose the actual and potential impacts of climate-related risks and opportunities on the organization's businesses, strategy, and financial planning where such information is material.

<table>
<thead>
<tr>
<th>Recommended Disclosure c)</th>
<th>Guidance for All Sectors</th>
</tr>
</thead>
</table>
| Describe the resilience of the organization's strategy, taking into consideration different climate-related scenarios, including a 2°C or lower scenario. | Organizations should describe how resilient their strategies are to climate-related risks and opportunities, taking into consideration a transition to a lower-carbon economy consistent with a 2°C or lower scenario and, where relevant to the organization, scenarios consistent with increased physical climate-related risks. Organizations should consider discussing:  
- where they believe their strategies may be affected by climate-related risks and opportunities;  
- how their strategies might change to address such potential risks and opportunities; and  
- the climate-related scenarios and associated time horizon(s) considered.  
Refer to Section D for information on applying scenarios to forward-looking analysis. |

### c. Risk Management

Investors and other stakeholders need to understand how an organization's climate-related risks are identified, assessed, and managed and whether those processes are integrated into existing risk management processes. Such information supports users of climate-related financial disclosures in evaluating the organization's overall risk profile and risk management activities.

<table>
<thead>
<tr>
<th>Recommended Disclosure a)</th>
<th>Guidance for All Sectors</th>
</tr>
</thead>
</table>
| Describe the organization's processes for identifying and assessing climate-related risks. | Organizations should describe their risk management processes for identifying and assessing climate-related risks. An important aspect of this description is how organizations determine the relative significance of climate-related risks in relation to other risks. Organizations should describe whether they consider existing and emerging regulatory requirements related to climate change (e.g., limits on emissions) as well as other relevant factors considered. Organizations should also consider disclosing the following:  
- processes for assessing the potential size and scope of identified climate-related risks and  
- definitions of risk terminology used or references to existing risk classification frameworks used. |

<table>
<thead>
<tr>
<th>Recommended Disclosure b)</th>
<th>Guidance for All Sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe the organization's processes for managing climate-related risks.</td>
<td>Organizations should describe their processes for managing climate-related risks, including how they make decisions to mitigate, transfer, accept, or control those risks. In addition, organizations should describe their processes for prioritizing climate-related risks, including how materiality determinations are made within their organizations. In describing their processes for managing climate-related risks, organizations should address the risks included in Tables 1 and 2 (pp. 10-11), as appropriate.</td>
</tr>
</tbody>
</table>
Recommendations of the Task Force on Climate-related Financial Disclosures

APPENDIX B

Risk Management

Disclose how the organization identifies, assesses, and manages climate-related risks.

<table>
<thead>
<tr>
<th>Recommended Disclosure c)</th>
<th>Guidance for All Sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe how processes for identifying, assessing, and managing climate-related risks are integrated into the organization's overall risk management.</td>
<td>Organizations should describe how their processes for identifying, assessing, and managing climate-related risks are integrated into their overall risk management.</td>
</tr>
</tbody>
</table>

d. Metrics and Targets

Investors and other stakeholders need to understand how an organization measures and monitors its climate-related risks and opportunities. Access to the metrics and targets used by an organization allows investors and other stakeholders to better assess the organization's potential risk-adjusted returns, ability to meet financial obligations, general exposure to climate-related issues, and progress in managing or adapting to those issues. They also provide a basis upon which investors and other stakeholders can compare organizations within a sector or industry.

Metrics and Targets

Disclose the metrics and targets used to assess and manage relevant climate-related risks and opportunities where such information is material.

<table>
<thead>
<tr>
<th>Recommended Disclosure a)</th>
<th>Guidance for All Sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disclose the metrics used by the organization to assess climate-related risks and opportunities in line with its strategy and risk management process.</td>
<td>Organizations should provide the key metrics used to measure and manage climate-related risks and opportunities, as described in Tables 1 and 2 (pp. 10-11). Organizations should consider including metrics on climate-related risks associated with water, energy, land use, and waste management where relevant and applicable. Where climate-related issues are material, organizations should consider describing whether and how related performance metrics are incorporated into remuneration policies. Where relevant, organizations should provide their internal carbon prices as well as climate-related opportunity metrics such as revenue from products and services designed for a lower-carbon economy. Metrics should be provided for historical periods to allow for trend analysis. In addition, where not apparent, organizations should provide a description of the methodologies used to calculate or estimate climate-related metrics.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommended Disclosure b)</th>
<th>Guidance for All Sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disclose Scope 1, Scope 2, and, if appropriate, Scope 3 greenhouse gas (GHG) emissions, and the related risks.</td>
<td>Organizations should provide their Scope 1 and Scope 2 GHG emissions and, if appropriate, Scope 3 GHG emissions and the related risks. GHG emissions should be calculated in line with the GHG Protocol methodology to allow for aggregation and comparability across organizations and jurisdictions. As appropriate, organizations should consider providing related, generally accepted industry-specific GHG efficiency ratios. GHG emissions and associated metrics should be provided for historical periods to allow for trend analysis.</td>
</tr>
</tbody>
</table>

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39 Emissions are a prime driver of rising global temperatures and, as such, are a key focal point of policy, regulatory, market, and technology responses to limit climate change. As a result, organizations with significant emissions are likely to be impacted more significantly by transition risk than other organizations. In addition, current or future constraints on emissions, either directly by emission restrictions or indirectly through carbon budgets, may impact organizations financially.

40 While challenges remain, the GHG Protocol methodology is the most widely recognized and used international standard for calculating GHG emissions. Organizations may use national reporting methodologies if they are consistent with the GHG Protocol methodology.

41 For industries with high energy consumption, metrics related to emission intensity are important to provide. For example, emissions per unit of economic output (e.g., unit of production, number of employees, or value-added) is widely used. See the Annex for examples of metrics.
## Metrics and Targets

Disclose the metrics and targets used to assess and manage relevant climate-related risks and opportunities where such information is material.

### Recommended Disclosure c)

Describe the targets used by the organization to manage climate-related risks and opportunities and performance against targets.

### Guidance for All Sectors

Organizations should describe their key climate-related targets such as those related to GHG emissions, water usage, energy usage, etc., in line with anticipated regulatory requirements or market constraints or other goals. Other goals may include efficiency or financial goals, financial loss tolerances, avoided GHG emissions through the entire product life cycle, or net revenue goals for products and services designed for a lower-carbon economy.

In describing their targets, organizations should consider including the following:

- whether the target is absolute or intensity based,
- time frames over which the target applies,
- base year from which progress is measured, and
- key performance indicators used to assess progress against targets.

Where not apparent, organizations should provide a description of the methodologies used to calculate targets and measures.
D Scenario Analysis and Climate-Related Issues
D Scenario Analysis and Climate-Related Issues

Some organizations are affected by risks associated with climate change today. However, for many organizations, the most significant effects of climate change are likely to emerge over the medium to longer term and their timing and magnitude are uncertain. This uncertainty presents challenges for individual organizations in understanding the potential effects of climate change on their businesses, strategies, and financial performance. To appropriately incorporate the potential effects in their planning processes, organizations need to consider how their climate-related risks and opportunities may evolve and the potential implications under different conditions. One way to do this is through scenario analysis.

Scenario analysis is a well-established method for developing strategic plans that are more flexible or robust to a range of plausible future states. The use of scenario analysis for assessing the potential business implications of climate-related risks and opportunities, however, is relatively recent. While several organizations use scenario analysis to assess the potential impact of climate change on their businesses, only a subset have disclosed their assessment of forward-looking implications publicly, either in sustainability reports or financial filings.42

The disclosure of organizations' forward-looking assessments of climate-related issues is important for investors and other stakeholders in understanding how vulnerable individual organizations are to transition and physical risks and how such vulnerabilities are or would be addressed. As a result, the Task Force believes that organizations should use scenario analysis to assess potential business, strategic, and financial implications of climate-related risks and opportunities and disclose those, as appropriate, in their annual financial filings.

Scenario analysis is an important and useful tool for understanding the strategic implications of climate-related risks and opportunities.

This section provides additional information on using scenario analysis as a tool to assess potential implications of climate-related risks and opportunities. In addition, a technical supplement, The Use of Scenario Analysis in Disclosure of Climate-Related Risks and Opportunities, on the Task Force's website provides further information on the types of climate-related scenarios, the application of scenario analysis, and the key challenges in implementing scenario analysis.

1. Overview of Scenario Analysis

Scenario analysis is a process for identifying and assessing the potential implications of a range of plausible future states under conditions of uncertainty. Scenarios are hypothetical constructs and not designed to deliver precise outcomes or forecasts. Instead, scenarios provide a way for organizations to consider how the future might look if certain trends continue or certain conditions are met. In the case of climate change, for example, scenarios allow an organization to explore and develop an understanding of how various combinations of climate-related risks, both transition and physical risks, may affect its businesses, strategies, and financial performance over time.

Scenario analysis can be qualitative, relying on descriptive, written narratives, or quantitative, relying on numerical data and models, or some combination of both. Qualitative scenario analysis

42 Some organizations in the energy sector and some large investors have made public disclosures describing the results of their climate-related scenario analysis, including discussing how the transition might affect their current portfolios. In some instances, this information was published in financial filings.
explores relationships and trends for which little or no numerical data is available, while quantitative scenario analysis can be used to assess measurable trends and relationships using models and other analytical techniques.43 Both rely on scenarios that are internally consistent, logical, and based on explicit assumptions and constraints that result in plausible future development paths.

As summarized in Figure 7, there are several reasons why scenario analysis is a useful tool for organizations in assessing the potential implications of climate-related risks and opportunities.

**Figure 7**

**Reasons to Consider Using Scenario Analysis for Climate Change**

1. Scenario analysis can help organizations consider issues, like climate change, that have the following characteristics:
   - Possible outcomes that are highly uncertain (e.g., the physical response of the climate and ecosystems to higher levels of GHG emissions in the atmosphere)
   - Outcomes that will play out over the medium to longer term (e.g., timing, distribution, and mechanisms of the transition to a lower-carbon economy)
   - Potential disruptive effects that, due to uncertainty and complexity, are substantial

2. Scenario analysis can enhance organizations’ strategic conversations about the future by considering, in a more structured manner, what may unfold that is different from business-as-usual. Importantly, it broadens decision makers’ thinking across a range of plausible scenarios, including scenarios where climate-related impacts can be significant.

3. Scenario analysis can help organizations frame and assess the potential range of plausible business, strategic, and financial impacts from climate change and the associated management actions that may need to be considered in strategic and financial plans. This may lead to more robust strategies under a wider range of uncertain future conditions.

4. Scenario analysis can help organizations identify indicators to monitor the external environment and better recognize when the environment is moving toward a different scenario state (or to a different stage along a scenario path). This allows organizations the opportunity to reassess and adjust their strategies and financial plans accordingly.44

5. Scenario analysis can assist investors in understanding the robustness of organizations’ strategies and financial plans and in comparing risks and opportunities across organizations.

**2. Exposure to Climate-Related Risks**

The effects of climate change on specific sectors, industries, and individual organizations are highly variable. It is important, therefore, that all organizations consider applying a basic level of scenario analysis in their strategic planning and risk management processes. Organizations more significantly affected by transition risk (e.g., fossil fuel-based industries, energy-intensive manufacturers, and transportation activities) and/or physical risk (e.g., agriculture, transportation

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44 J.N. Maack, Scenario analysis: a tool for task managers, Social Analysis: selected tools and techniques, Social Development Papers, Number 36, the World Bank, June 2001, Washington, DC.
and building infrastructure, insurance, and tourism) should consider a more in-depth application of scenario analysis.

**a. Exposure to Transition Risks**
Transition risk scenarios are particularly relevant for resource-intensive organizations with high GHG emissions within their value chains, where policy actions, technology, or market changes aimed at emissions reductions, energy efficiency, subsidies or taxes, or other constraints or incentives may have a particularly direct effect.

A key type of transition risk scenario is a so-called 2°C scenario, which lays out a pathway and an emissions trajectory consistent with holding the increase in the global average temperature to 2°C above pre-industrial levels. In December 2015, nearly 200 governments agreed to strengthen the global response to the threat of climate change by “holding the increase in the global average temperature to well below 2°C above pre-industrial levels and to pursue efforts to limit the temperature increase to 1.5°C above pre-industrial levels,” referred to as the Paris Agreement. As a result, a 2°C scenario provides a common reference point that is generally aligned with the objectives of the Paris Agreement and will support investors’ evaluation of the potential magnitude and timing of transition-related implications for individual organizations; across different organizations within a sector; and across different sectors.

**b. Exposure to Physical Risks**
A wide range of organizations are exposed to climate-related physical risks. Physical climate-related scenarios are particularly relevant for organizations exposed to acute or chronic climate change, such as those with:

- long-lived, fixed assets;
- locations or operations in climate-sensitive regions (e.g., coastal and flood zones);
- reliance on availability of water; and
- value chains exposed to the above.

Physical risk scenarios generally identify extreme weather threats of moderate or higher risk before 2030 and a larger number and range of physical threats between 2030 and 2050. Although most climate models deliver scenario results for physical impacts beyond 2050, organizations typically focus on the consequences of physical risk scenarios over shorter time frames that reflect the lifetimes of their respective assets or liabilities, which vary across sectors and organizations.

### 3. Recommended Approach to Scenario Analysis

The Task Force believes that all organizations exposed to climate-related risks should consider (1) using scenario analysis to help inform their strategic and financial planning processes and (2) disclosing how resilient their strategies are to a range of plausible climate-related scenarios. The Task Force recognizes that, for many organizations, scenario analysis is or would be a largely qualitative exercise. However, organizations with more significant exposure to transition risk and/or physical risk should undertake more rigorous qualitative and, if relevant, quantitative scenario analysis with respect to key drivers and trends that affect their operations.

A critical aspect of scenario analysis is the selection of a set of scenarios (not just one) that covers a reasonable variety of future outcomes, both favorable and unfavorable. In this regard, the Task Force recommends organizations use a 2°C or lower scenario in addition to two or three other...
scenarios most relevant to their circumstances, such as scenarios related to Nationally Determined Contributions (NDCs), physical climate-related scenarios, or other challenging scenarios. In jurisdictions where NDCs are a commonly accepted guide for an energy and/or emissions pathway, NDCs may constitute particularly useful scenarios to include in an organization’s suite of scenarios for conducting climate-related scenario analysis.

For an organization in the initial stages of implementing scenario analysis or with limited exposure to climate-related issues, the Task Force recommends disclosing how resilient, qualitatively or directionally, the organization’s strategy and financial plans may be to a range of relevant climate change scenarios. This information helps investors, lenders, insurance underwriters, and other stakeholders understand the robustness of an organization’s forward-looking strategy and financial plans across a range of possible future states.

Organizations with more significant exposure to climate-related issues should consider disclosing key assumptions and pathways related to the scenarios they use to allow users to understand the analytical process and its limitations. In particular, it is important to understand the critical parameters and assumptions that materially affect the conclusions drawn. As a result, the Task Force believes that organizations with significant climate-related exposures should strive to disclose the elements described in Figure 8.

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**Figure 8**

**Disclosure Considerations for Non-Financial Organizations**

Organizations with more significant exposure to climate-related issues should consider disclosing key aspects of their scenario analysis, such as the ones described below.

1. The scenarios used, including the 2°C or lower scenario[^47]

2. Critical input parameters, assumptions, and analytical choices for the scenarios used, including such factors as:
   - Assumptions about possible technology responses and timing (e.g., evolution of products/services, the technology used to produce them, and costs to implement)
   - Assumptions made around potential differences in input parameters across regions, countries, asset locations, and/or markets
   - Approximate sensitivities to key assumptions

3. Time frames used for scenarios, including short-, medium-, and long-term milestones (e.g., how organizations consider timing of potential future implications under the scenarios used)

4. Information about the resiliency of the organization’s strategy, including strategic performance implications under the various scenarios considered, potential qualitative or directional implications for the organization’s value chain, capital allocation decisions, research and development focus, and potential material financial implications for the organization’s operating results and/or financial position

[^46]: The Task Force’s technical supplement, *The Use of Scenario Analysis in Disclosure of Climate-Related Risks and Opportunities* provides more information on scenario inputs, analytical assumptions and choices, and assessment and presentation of potential impacts.

[^47]: The objective of the Paris Agreement is to hold the increase in the global average temperature to well below 2°C above pre-industrial levels and to pursue efforts to limit the temperature increase to 1.5°C. The IEA is developing a 1.5°C scenario that organizations may find useful.
4. Applying Scenario Analysis

While the Task Force recognizes the complexities of scenario analysis and the potential resources needed to conduct it, organizations are encouraged to use scenario analysis to assess climate-related risks and opportunities. For organizations just beginning to use scenario analysis, a qualitative approach that progresses and deepens over time may be appropriate. Greater rigor and sophistication in the use of data and quantitative models and analysis may be warranted for organizations with more extensive experience in conducting scenario analysis. Organizations may decide to use existing external scenarios and models (e.g., those provided by third-party vendors) or develop their own, in-house modeling capabilities. The choice of approach will depend on an organization’s needs, resources, and capabilities.

In conducting scenario analysis, organizations should strive to achieve:

- transparency around parameters, assumptions, analytical approaches, and time frames;
- comparability of results across different scenarios and analytical approaches;
- adequate documentation for the methodology, assumptions, data sources, and analytics;
- consistency of methodology year over year;
- sound governance over scenario analysis conduct, validation, approval, and application; and
- effective disclosure of scenario analysis that will inform and promote a constructive dialogue between investors and organizations on the range of potential impacts and resilience of the organization’s strategy under various plausible climate-related scenarios.

In applying scenario analysis, organizations should consider general implications for their strategies, capital allocation, and costs and revenues, both at an enterprise-wide level and at the level of specific regions and markets where specific implications of climate change for the organization are likely to arise. Financial-sector organizations should consider using scenario analysis to evaluate the potential impact of climate-related scenarios on individual assets or investments, investments or assets in a particular sector or region, or underwriting activities.

The Task Force’s supplemental guidance recognizes that organizations will be at different levels of experience in using scenario analysis. However, it is important for organizations to use scenario analysis and develop the necessary organizational skills and capabilities to assess climate-related risks and opportunities, with the expectation that organizations will evolve and deepen their use of scenario analysis over time. The objective is to assist investors and other stakeholders in better understanding:

- the degree of robustness of the organization’s strategy and financial plans under different plausible future states of the world;
- how the organization may be positioning itself to take advantage of opportunities and plans to mitigate or adapt to climate-related risks; and
- how the organization is challenging itself to think strategically about longer-term climate-related risks and opportunities.

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48 Organizations considering undertaking scenario analysis may wish to conduct various sensitivity analyses around key climate factors as a precursor to scenario analysis, recognizing that sensitivity analysis and scenario analysis are different, but complementary, processes.
5. Challenges and Benefits of Conducting Scenario Analysis

Scenario analysis is a well-established method for developing strategic plans that are more flexible and robust to a range of plausible future states. As previously discussed (Figure 7, p. 26) it is particularly useful for assessing issues with possible outcomes that are highly uncertain, that play out over the medium to longer term, and that are potentially disruptive. Scenario analysis can help to better frame strategic issues, assess the range of potential management actions that may be needed, engage more productively in strategic conversations, and identify indicators to monitor the external environment. Importantly, climate-related scenario analysis can provide the foundation for more effective engagement with investors on an organization’s strategic and business resiliency.

Conducting climate-related scenario analysis, however, is not without challenges. First, most scenarios have been developed for global and macro assessments of potential climate-related impacts that can inform policy makers. These climate-related scenarios do not always provide the ideal level of transparency, range of data outputs, and functionality of tools that would facilitate their use in a business or investment context.

Second, the availability and granularity of data can be a challenge for organizations attempting to assess various energy and technology pathways or carbon constraints in different jurisdictions and geographic locations.

Third, the use of climate-related scenario analysis to assess potential business implications is still at an early stage. Although a handful of the largest organizations and investors are using climate-related scenario analysis as part of their strategic planning and risk management processes, many organizations are just beginning to explore its use. Sharing experiences and approaches to climate-related scenario analysis across organizations, therefore, is critical to advancing the use of climate-related scenario analysis. Organizations may be able to play an important role in this regard by facilitating information and experience exchanges among themselves; collectively developing tools, data sets, and methodologies; and working to set standards. Organizations across many different sectors will inevitably need to learn by doing. Some may seek guidance from other industry participants and experts on how to apply climate-related scenarios to make forward-looking analyses of climate-related risks and opportunities.

Addressing these challenges and advancing the use of climate-related scenario analysis will require further work. These challenges, however, are not insurmountable and can be addressed. Organizations should undertake scenario analysis in the near term to capture the important benefits for assessing climate-related risks and opportunities and improve their capabilities as tools and data progress over time.
E Key Issues Considered and Areas for Further Work
E  Key Issues Considered and Areas for Further Work

The diverse perspectives of Task Force members as well as outreach efforts, including two public consultations, resulting in over 500 responses, hundreds of industry interviews, several focus groups, and multiple webinars, provided valuable insight into the challenges that different organizations—both financial and non-financial—may encounter in preparing disclosures consistent with the Task Force's recommendations. The Task Force considered these issues and others in developing and then finalizing its recommendations and sought to balance the burden of disclosure on preparers with the need for consistent and decision-useful information for users (i.e., investors, lenders, and insurance underwriters). This section describes the key issues considered by the Task Force, significant public feedback received by the Task Force related to those issues, the ultimate disposition of the issues, and, in some cases, areas where further work may be warranted. Figure 9 summarizes areas the Task Force identified, through its own analysis as well as through public feedback, as warranting further research and analysis or the development of methodologies and standards.

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**Figure 9**

**Key Areas for Further Work**

| Relationship to Other Reporting Initiatives | Encourage standard setting organizations and others to actively work toward greater alignment of frameworks and to support adoption |
| Scenario Analysis | Further develop applicable 2°C or lower transition scenarios and supporting outputs, tools, and user interfaces |
| | Develop broadly accepted methodologies, datasets, and tools for scenario-based evaluation of physical risk by organizations |
| | Make datasets and tools publicly available and provide commonly available platforms for scenario analysis |
| Data Availability and Quality and Financial Impact | Undertake further research and analysis to better understand and measure how climate-related issues translate into potential financial impacts for organizations in financial and non-financial sectors |
| | Improve data quality and further develop standardized metrics for the financial sector, including better defining carbon-related assets and developing metrics that address a broader range of climate-related risks and opportunities |
| | Increase organizations’ understanding of climate-related risks and opportunities |
| Example Disclosures | Provide example disclosures to assist preparers in developing disclosures consistent with the Task Force’s recommendations |

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*In response to the second consultation, organizations asked for example disclosures to gain a better understanding of how the recommended information may be disclosed. The Task Force acknowledges the development of these examples as an area of further work.*
1. Relationship to Other Reporting Initiatives

Through the Task Force’s outreach efforts, some organizations expressed concern that multiple disclosure frameworks and mandatory reporting requirements increase the administrative burden of disclosure efforts. Specifically, the additional time, cost, and effort required to analyze and disclose new climate-related information could penalize those with less capacity to respond.

The Task Force considered existing voluntary and mandatory climate-related reporting frameworks in developing its recommendations and provides information in the Annex on the alignment of existing frameworks, including those developed by the CDP (formerly the Carbon Disclosure Project), Climate Disclosure Standards Board (CDSB), the Global Reporting Initiative (GRI), the International Integrated Reporting Council (IIRC), and the Sustainability Accounting Standards Board (SASB), with the Task Force’s recommended disclosures. The Task Force expects preparers disclosing climate-related information under other regimes will be able to use existing processes and content when developing disclosures based on the Task Force’s recommendations.

The Task Force’s recommendations provide a common set of principles that should help existing disclosure regimes come into closer alignment over time. Preparers, users, and other stakeholders share a common interest in encouraging such alignment as it relieves a burden for reporting entities, reduces fragmented disclosure, and provides greater comparability for users. The Task Force also encourages standard setting bodies to support adoption of the recommendations and alignment with the recommended disclosures.

2. Location of Disclosures and Materiality

In considering possible reporting venues, the Task Force reviewed existing regimes for climate-related disclosures across G20 countries. While many G20 countries have rules or regulatory guidance that require climate-related disclosure for organizations, most are not explicitly focused on climate-related financial information.50 In addition, the locations of these disclosures vary significantly and range from surveys sent to regulators to sustainability reports to annual financial filings (see Appendix 4).

The Task Force also reviewed financial filing requirements applicable to public companies across G20 countries and found that in most G20 countries, issuers have a legal obligation to disclose material information in their financial reports—which includes material, climate-related information. Such reporting may take the form of a general disclosure of material information, but many jurisdictions require disclosure of material information in specific sections of the financial filing (e.g., in a discussion on risk factors).51

Based on its review, the Task Force determined that preparers of climate-related financial disclosures should provide such disclosures in their mainstream (i.e., public) annual financial filings.52 The Task Force believes publication of climate-related financial information in mainstream financial filings will foster broader utilization of such disclosures, promoting an informed understanding of climate-related issues by investors and others, and support shareholder engagement. Importantly, in determining whether information is material, the Task Force believes organizations should determine materiality for climate-related issues consistent with how they determine the materiality of other information included in their financial filings. In addition, the Task Force cautions organizations against prematurely concluding that climate-
related risks and opportunities are not material based on perceptions of the longer-term nature of some climate-related risks.

As part of the Task Force’s second public consultation, some organizations expressed concern about disclosing information in financial filings that is not clearly tied to an assessment of materiality. The Task Force recognizes organizations’ concerns about disclosing information in annual financial filings that is not clearly tied to an assessment of materiality. However, the Task Force believes disclosures related to the Governance and Risk Management recommendations should be provided in annual financial filings. Because climate-related risk is a non-diversifiable risk that affects nearly all sectors, many investors believe it requires special attention. For example, in assessing organizations’ financial and operating results, many investors want insight into the governance and risk management context in which such results are achieved. The Task Force believes disclosures related to its Governance and Risk Management recommendations directly address this need for context and should be included in annual financial filings.

For disclosures related to the Strategy and Metrics and Targets recommendations, the Task Force believes organizations should provide such information in annual financial filings when the information is deemed material. Certain organizations—those in the four non-financial groups that have more than one billion USDE in annual revenue—should consider disclosing information related to these recommendations in other reports when the information is not deemed material and not included in financial filings.53,54 Because these organizations are more likely than others to be affected financially over time due to their significant GHG emissions or energy or water dependencies, investors are interested in monitoring how the organizations’ strategies evolve.

In addition, the Task Force recognizes reporting by asset managers and asset owners to their clients and beneficiaries, respectively, generally occurs outside mainstream financial filings (Figure 10). For purposes of adopting the Task Force’s recommendations, asset managers and asset owners should use their existing channels of financial reporting to their clients and beneficiaries where relevant and feasible. Likewise, asset managers and asset owners should consider materiality in the context of their respective mandates and investment performance for clients and beneficiaries.

Figure 10
Reporting by Asset Owners
The financial reporting requirements and practices of asset owners vary widely and differ from what is required of organizations with public debt or equity. Some asset owners have no public reporting, while others provide extensive public reporting. For purposes of adopting the Task Force’s recommendations, asset owners should use their existing channels of financial reporting to their beneficiaries and others where relevant and feasible.

Reporting by Asset Managers
Reporting to clients by asset managers also takes different forms, depending on the requirements of the client and the types of investments made. For example, an investor in a mutual fund might receive quarterly, or download from the asset manager’s website, a “fund fact sheet” that reports, among other information, the top holdings by value, the top performers by returns, and the carbon footprint of the portfolio against a stated benchmark. An investor in a segregated account might receive more detailed reporting, including items such as the aggregate carbon intensity of the portfolio compared with a benchmark, the portfolio’s exposure to green revenue (and how this changes over time), or insight into portfolio positioning under different climate scenarios. The Task Force appreciates that climate-related risk reporting by asset managers is in the very early stages and encourages progress and innovation by the industry.

53 The Task Force chose a one billion USDE annual revenue threshold because it captures organizations responsible for over 90% of Scope 1 and 2 GHG emissions in the industries represented by the four non-financial groups (about 2,250 organizations out of roughly 15,000).
54 “Other reports” should be official company reports that are issued at least annually, widely distributed and available to investors and others, and subject to internal governance processes that are substantially similar to those used for financial reporting.
3. Scenario Analysis

As part of the Task Force’s second public consultation, many organizations said scenario analysis is a useful tool to help assess risks and understand potential implications of climate change; however, they also identified areas where the Task Force’s recommendations and guidance could be improved. In particular, organizations asked the Task Force to identify standardized climate-related scenarios for organizations to use and clarify the information related to scenarios that should be disclosed. They also noted expectations around disclosures and climate-related scenario analysis should be proportionate to the size of the reporting entity and not onerous for smaller organizations. In addition, some organizations noted that the disclosures related to strategy could put organizations at greater risk of litigation given the high degree of uncertainty around the future timing and magnitude of climate-related impacts.

In finalizing its recommendations and guidance, the Task Force clarified organizations should describe how resilient their strategies are to climate-related risks and opportunities, taking into consideration a transition to a lower-carbon economy consistent with a 2°C or lower scenario and, where relevant, scenarios consistent with more extreme physical risks. To address concerns about proportionality, the Task Force established a threshold for organizations in the four non-financial groups that should perform more robust scenario analysis and disclose additional information on the resiliency of their strategies.

On the issue of recommending specific standardized or reference climate-related scenarios for organizations to use, Task Force members agreed that while such an approach is intuitively appealing, it is not a practical solution at this time. Existing, publicly available climate-related scenarios are not structured or defined in such a way that they can be easily applied consistently across different industries or across organizations within an industry.

The Task Force recognizes that incorporating scenario analysis into strategic planning processes will improve over time as organizations “learn by doing.” To facilitate progress in this area, the Task Force encourages further work as follows:

- further developing 2°C or lower transition scenarios that can be applied to specific industries and geographies along with supporting outputs, tools, and user interfaces;
- developing broadly accepted methodologies, data sets, and tools for scenario-based evaluation of physical risk by organizations;
- making these data sets and tools publicly available to facilitate use by organizations, reduce organizational transaction costs, minimize gaps between jurisdictions in terms of technical expertise, enhance comparability of climate-related risk assessments by organizations, and help ensure comparability for investors; and
- creating more industry specific (financial and non-financial) guidance for preparers and users of climate-related scenarios.

4. Data Availability and Quality and Financial Impact

The Task Force developed supplemental guidance for the four non-financial groups that account for the largest proportion of GHG emissions, energy usage, and water usage; and, as part of that supplemental guidance, the Task Force included several illustrative metrics around factors that may be indicative of potential financial implications for climate-related risks and opportunities. As part of the second public consultation, several organizations provided feedback on the illustrative metrics, and common themes included (1) improving the comparability and consistency of the metrics, (2) clarifying the links among the metrics, climate-related risks and opportunities, and potential financial implications, (3) simplifying the metrics, and (4) providing additional guidance on the metrics, including how to calculate key metrics. Organizations also raised concerns about
the lack of standardized data and metrics in the financial sector, which complicates preparers' ability to develop decision-useful metrics and users' ability to compare metrics across organizations.

The Task Force recognizes these concerns as well as broader challenges related to data availability and quality, as described below.

- The gaps in emissions measurement methodologies, including Scope 3 emissions and product life-cycle emissions methodologies, make reliable and accurate estimates difficult.\textsuperscript{55,56}
- The lack of robust and cost-effective tools to quantify the potential impact of climate-related risks and opportunities at the asset and project level makes aggregation across an organization's activities or investment portfolios problematic and costly.
- The need to consider the variability of climate-related impacts across and within different sectors and markets further complicates the process (and magnifies the cost) of assessing potential climate-related financial impacts.
- The high degree of uncertainty around the timing and magnitude of climate-related risks makes it difficult to determine and disclose the potential impacts with precision.

In finalizing its supplemental guidance, the Task Force addressed the redundancy of the metrics; simplified the non-financial illustrative metrics tables; ensured consistent terminology was used; and clarified the links between the metrics, climate-related risks and opportunities, and potential financial implications. In addition, the Task Force encourages further research and analysis by sector and industry experts to (1) better understand and measure how climate-related issues translate into potential financial impacts; (2) develop standardized metrics for the financial sector, including better defining carbon-related assets; and (3) increase organizations' understanding of climate-related risks and opportunities. As it relates to the broader challenges with data quality and availability, the Task Force encourages preparers to include in their disclosures a description of gaps, limitations, and assumptions made as part of their assessment of climate-related issues.

5. GHG Emissions Associated with Investments

In its supplemental guidance for asset owners and asset managers issued on December 14, 2016, the Task Force asked such organizations to provide GHG emissions associated with each fund, product, or investment strategy normalized for every million of the reporting currency invested. As part of the Task Force's public consultation as well as in discussions with preparers, some asset owners and asset managers expressed concern about reporting on GHG emissions related to their own or their clients' investments given the current data challenges and existing accounting guidance on how to measure and report GHG emissions associated with investments. In particular, they voiced concerns about the accuracy and completeness of the reported data and limited application of the metric to asset classes beyond public equities. Organizations also highlighted that GHG emissions associated with investments cannot be used as a sole indicator for investment decisions (i.e., additional metrics are needed) and that the metric can fluctuate with share price movements since it uses investors' proportional share of total equity.\textsuperscript{57}

In consideration of the feedback received, the Task Force has replaced the GHG emissions associated with investments metric in the supplemental guidance for asset owners and asset managers with a weighted average carbon intensity metric. The Task Force believes the weighted

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\textsuperscript{55} Scope 3 emissions are all indirect emissions that occur in the value chain of the reporting company, including both upstream and downstream emissions. See Greenhouse Gas Protocol, "Calculation Tools, FAQ."

\textsuperscript{56} Product life cycle emissions are all the emissions associated with the production and use of a specific product, including emissions from raw materials, manufacture, transport, storage, sale, use, and disposal. See Greenhouse Gas Protocol, "Calculation Tools, FAQ."

\textsuperscript{57} Because the metric uses investors' proportional share of total equity, increases in the underlying companies' share prices, all else equal, will result in a decrease in the carbon footprinting number even though GHG emissions are unchanged.
average carbon intensity metric, which measures exposure to carbon-intensive companies, addresses many of the concerns raised. For example, the metric can be applied across asset classes, is fairly simple to calculate, and does not use investors' proportional share of total equity and, therefore, is not sensitive to share price movements.

The Task Force acknowledges the challenges and limitations of current carbon footprinting metrics, including that such metrics should not necessarily be interpreted as risk metrics. Nevertheless, the Task Force views the reporting of weighted average carbon intensity as a first step and expects disclosure of this information to prompt important advancements in the development of decision-useful, climate-related risk metrics. In this regard, the Task Force encourages asset owners and asset managers to provide other metrics they believe are useful for decision making along with a description of the methodology used. The Task Force recognizes that some asset owners and asset managers may be able to report the weighted average carbon intensity and other metrics on only a portion of their investments given data availability and methodological issues. Nonetheless, increasing the number of organizations reporting this type of information should help speed the development of better climate-related risk metrics.

6. Remuneration

In the supplemental guidance for the Energy Group, the Task Force asked such organizations to consider disclosing whether and how performance metrics, including links to remuneration policies, take into consideration climate-related risks and opportunities. As part of its second public consultation, the Task Force asked whether the guidance should extend to organizations beyond those in the Energy group and, if so, to which types of organizations. The majority of organizations that commented on this issue responded that the guidance should be extended to other organizations; and many suggested that the guidance should apply to organizations more likely to be affected by climate-related risks. In consideration of the feedback received, the Task Force revised its guidance to ask organizations, where climate-related risks are material, to consider describing whether and how related performance metrics are incorporated into remuneration policies.

7. Accounting Considerations

As part of its work, the Task Force considered the interconnectivity of its recommendations with existing financial statement and disclosure requirements. The Task Force determined that the two primary accounting standard setting bodies, the International Accounting Standards Board (IASB) and the Financial Accounting Standards Board (FASB), have issued standards to address risks and uncertainties affecting companies. Both International Accounting Standard (IAS) 37 “Provisions, Contingent Liabilities and Contingent Assets” and Accounting Standards Codification (ASC) 450 “Contingencies” provide guidance on how to account for and disclose contingencies. Additionally, IAS 36 “Impairment of Assets” and ASC 360 “Long-lived Asset Impairment” provide guidance on assessing the impairment of long-lived assets. The disclosures of both contingencies and management’s assessment and evaluation of long-lived assets for potential impairment are critically important in assisting stakeholders in understanding an organization’s ability to meet future reported earnings and cash flow goals.

In most G20 countries, financial executives will likely recognize that the Task Force's disclosure recommendations should result in more quantitative financial disclosures, particularly disclosure of metrics, about the financial impact that climate-related risks have or could have on an organization. Specifically, asset impairments may result from assets adversely impacted by the effects of climate change and/or additional liabilities may need to be recorded to account for regulatory fines and penalties resulting from enhanced regulatory standards. Additionally, cash flows from operations, net income, and access to capital could all be impacted by the effects of...
climate-related risks (and opportunities). Therefore, financial executives (e.g., chief financial officers, chief accounting officers, and controllers) should be involved in the organization’s evaluation of climate-related risks and opportunities and the efforts undertaken to manage the risks and maximize the opportunities. Finally, careful consideration should be given to the linkage between scenario analyses performed to assess the resilience of an organization’s strategy to climate-related risks and opportunities (as suggested in the Task Force’s recommendations) and assumptions underlying cash flow analyses used to assess asset (e.g., goodwill, intangibles, and fixed assets) impairments.

8. Time Frames for Short, Medium, and Long Term
As part of the Task Force’s second public consultation, some organizations asked the Task Force to define specific ranges for short, medium, and long term. Because the timing of climate-related impacts on organizations will vary, the Task Force believes specifying time frames across sectors for short, medium, and long term could hinder organizations’ consideration of climate-related risks and opportunities specific to their businesses. The Task Force is, therefore, not defining time frames and encourages preparers to decide how to define their own time frames according to the life of their assets, the profile of the climate-related risks they face, and the sectors and geographies in which they operate.

In assessing climate-related issues, organizations should be sensitive to the time frames used to conduct their assessments. While many organizations conduct operational and financial planning over a 1-2 year time frame and strategic and capital planning over a 2-5 year time frame, climate-related risks may have implications for an organization over a longer period. It is, therefore, important for organizations to consider the appropriate time frames when assessing climate-related risks.

9. Scope of Coverage
To promote more informed investing, lending, and insurance underwriting decisions, the Task Force recommends all financial and non-financial organizations with public debt and/or equity adopt its recommendations. Because climate-related risks and opportunities are relevant for organizations across all sectors, the Task Force encourages all organizations to adopt these recommendations. In addition, the Task Force believes that asset managers and asset owners, including public- and private-sector pension plans, endowments, and foundations, should implement its recommendations. The Task Force believes climate-related financial information should be provided to asset managers’ clients and asset owners’ beneficiaries so that they may better understand the performance of their assets, consider the risks of their investments, and make more informed investment choices.

Consistent with existing global stewardship frameworks, asset owners should engage with the organizations in which they invest to encourage adoption of these recommendations. They should also ask their asset managers to adopt these recommendations. Asset owners’ expectations in relation to climate-related risk reporting from organizations and asset managers are likely to evolve as data availability and quality improves, understanding of climate-related risk increases, and risk measurement methodologies are further developed.

The Task Force recognizes that several asset owners expressed concern about being identified as the potential “policing body” charged with ensuring adoption of the Task Force’s recommendations by asset managers and underlying organizations. The Task Force appreciates that expectations must be reasonable and that asset owners have many competing priorities, but

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58 Thresholds for climate-related financial disclosures should be aligned to the financial disclosure requirements more broadly in the jurisdictions where a preparer is incorporated and/or operates and is required to make financial disclosures.
encourages them to help drive adoption of the recommendations. Because asset owners and asset managers sit at the top of the investment chain, they have an important role to play in influencing the organizations in which they invest to provide better climate-related financial disclosures.

10. Organizational Ownership

Some organizations have not formalized responsibility for climate-related risk assessment and management. Even for organizations with clearly assigned responsibilities for climate-related issues, the relationship between those responsible for climate-related risk (e.g., “environmental, social and governance” experts, chief investment officers) and those in the finance function can range from regularly scheduled interactions and exchanges of information to minimal or no interaction. According to some preparers, lack of clarity around responsibility for climate-related risk assessments and management, compounded by a lack of integration into organizations’ financial reporting processes, could adversely affect implementation of the recommendations.

The Task Force believes that by encouraging disclosure of climate-related financial information in public financial filings, coordination between organizations’ climate-related risk experts and the finance function will improve. Similar to the way organizations are evolving to include cyber security issues in their strategic and financial planning efforts, so too should they evolve for climate-related issues.
F Conclusion
F. Conclusion

The Task Force's recommendations are a foundation for improved reporting of climate-related issues in mainstream financial filings with several resulting benefits (outlined in Figure 11). The recommendations aim to be ambitious, but also practical for near-term adoption. The Task Force expects that reporting of climate-related risks and opportunities will evolve over time as organizations, investors, and others contribute to the quality and consistency of the information disclosed.

1. Evolution of Climate-Related Financial Disclosures

The Task Force recognizes that challenges exist, but all types of organizations can develop disclosures consistent with its recommendations. The recommendations provide a foundation for immediate adoption and are flexible enough to accommodate evolving practices. As understanding, data analytics, and modeling of climate-related issues become more widespread, disclosures can mature accordingly.

Organizations already reporting climate-related financial information under other frameworks may be well positioned to disclose under this framework immediately and are encouraged to do so. For such organizations, significant effort has gone into developing processes and collecting information needed for disclosing under these regimes. The Task Force expects these organizations will be able to use existing processes when providing disclosures in annual financial filings based on the Task Force's recommendations.59,60 Those with less experience can begin by considering and disclosing how climate-related issues may be relevant in their current governance, strategy, and risk management practices. This initial level of disclosure will allow investors to review, recognize, and understand how organizations consider climate-related issues and their potential financial impact.

Importantly, the Task Force recognizes organizations need to make financial disclosures in accordance with their national disclosure requirements. To the extent certain elements of the recommendations are incompatible with national disclosure requirements for financial filings, the Task Force encourages organizations to disclose those elements through other reports. Such other reports should be official company reports that are issued at least annually, widely distributed and available to investors and others, and subject to internal governance processes that are the same or substantially similar to those used for financial reporting.

2. Widespread Adoption Critical

In the Task Force's view, the success of its recommendations depends on near-term, widespread adoption by organizations in the financial and non-financial sectors. Through widespread adoption, financial risks and opportunities related to climate change will become a natural part of

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59 The Task Force recognizes the structure and content of financial filings differs across jurisdictions and, therefore, believes organizations are in the best position to determine where and how the recommended disclosures should be incorporated in financial filings.

60 The Task Force encourages organizations where climate-related issues could be material in the future to begin disclosing climate-related financial information outside financial filings to facilitate the incorporation of such information into financial filings once climate-related issues are determined to be material.
organizations’ risk management and strategic planning processes. As this occurs, organizations’ and investors’ understanding of the potential financial implications associated with transitioning to a lower-carbon economy and physical risks will grow, information will become more decision-useful, and risks and opportunities will be more accurately priced, allowing for the more efficient allocation of capital. Figure 12 outlines a possible path for implementation.

Widespread adoption of the recommendations will require ongoing leadership by the G20 and its member countries. Such leadership is essential to continue to make the link between these recommendations and the achievements of global climate objectives. Leadership from the FSB is also critical to underscore the importance of better climate-related financial disclosures for the functioning of the financial system.

The Task Force is not alone in its work. A variety of stakeholders, including stock exchanges, investment consultants, credit rating agencies, and others can provide valuable contributions toward adoption of the recommendations. The Task Force believes that advocacy for these standards will be necessary for widespread adoption, including educating organizations that will disclose climate-related financial information and those that will use those disclosures to make financial decisions. To this end, the Task Force notes that strong support by the FSB and G20 authorities would have a positive impact on implementation. With the FSB’s extension of the Task Force through September 2018, the Task Force will work to encourage adoption of the recommendations and support the FSB and G20 authorities in promoting the advancement of climate-related financial disclosures.
Appendices
# Appendix 1: Task Force Members

<table>
<thead>
<tr>
<th>Chairman and Vice Chairs</th>
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<tbody>
<tr>
<td><strong>Michael Bloomberg</strong></td>
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<tr>
<td>Chair</td>
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<tr>
<td>Founder</td>
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<tr>
<td>Bloomberg LP and Bloomberg Philanthropies</td>
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<tr>
<td><strong>Denise Pavarina</strong></td>
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<tr>
<td>Vice Chair</td>
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<tr>
<td>Executive Director</td>
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<tr>
<td>Banco Bradesco</td>
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<tr>
<td><strong>Graeme Pitkethly</strong></td>
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<tr>
<td>Vice Chair</td>
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<tr>
<td>Chief Financial Officer</td>
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<tr>
<td>Unilever</td>
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<tr>
<td><strong>Christian Thimann</strong></td>
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<tr>
<td>Vice Chair</td>
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<tr>
<td>Group Head of Regulation, Sustainability, and Insurance Foresight</td>
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<tr>
<td>AXA</td>
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<tr>
<td><strong>Yeo Lian Sim</strong></td>
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<tr>
<td>Vice Chair</td>
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<tr>
<td>Special Adviser, Diversity</td>
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<td>Singapore Exchange</td>
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<th>Members</th>
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<tr>
<td><strong>Jane Ambachtsheer</strong></td>
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<tr>
<td>Partner, Chair – Responsible Investment</td>
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<tr>
<td>Mercer</td>
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<td><strong>Wim Bartels</strong></td>
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<tr>
<td>Partner Corporate Reporting</td>
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<tr>
<td>KPMG</td>
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<tr>
<td><strong>David Blood</strong></td>
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<tr>
<td>Senior Partner</td>
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<tr>
<td>Generation Investment Management</td>
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<tr>
<td><strong>Koushik Chatterjee</strong></td>
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<tr>
<td>Group Executive Director, Finance and Corporate Tata Group</td>
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<tr>
<td><strong>Liliana Franco</strong></td>
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<tr>
<td>Director, Accounting Organization and Methods</td>
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<tr>
<td>Air Liquide Group</td>
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<tr>
<td><strong>Neil Hawkins</strong></td>
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<tr>
<td>Corporate Vice President and Chief Sustainability Officer</td>
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<tr>
<td>The Dow Chemical Company</td>
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<tr>
<td><strong>Diane Larsen</strong></td>
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<tr>
<td>Audit Partner, Global Professional Practice</td>
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<tr>
<td>EY</td>
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<tr>
<td><strong>Mark Lewis</strong></td>
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<tr>
<td>Managing Director, Head of European Utilities Equity Research</td>
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<tr>
<td>Barclays</td>
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<tr>
<td><strong>Matt Arnold</strong></td>
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<tr>
<td>Managing Director and Global Head of Sustainable Finance</td>
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<tr>
<td>JPMorgan Chase &amp; Co.</td>
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<tr>
<td><strong>Bruno Bertocci</strong></td>
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<tr>
<td>Managing Director, Head of Sustainable Investors</td>
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<tr>
<td>UBS Asset Management</td>
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<tr>
<td><strong>Richard Cantor</strong></td>
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<tr>
<td>Chief Risk Officer, Moody’s Corporation</td>
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<tr>
<td>Chief Credit Officer, Moody’s Investor Service</td>
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<tr>
<td><strong>Eric Dugelay</strong></td>
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<tr>
<td>Global Leader, Sustainability Services</td>
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<tr>
<td>Deloitte</td>
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<tr>
<td><strong>Udo Hartmann</strong></td>
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<tr>
<td>Senior Manager, Group Environmental Protection &amp; Energy Management</td>
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<tr>
<td>Daimler</td>
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<tr>
<td><strong>Thomas Kusterer</strong></td>
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<tr>
<td>Chief Financial Officer</td>
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<tr>
<td>EnBW Energie Baden-Württemberg AG</td>
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<tr>
<td><strong>Stephanie Leaist</strong></td>
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<tr>
<td>Managing Director, Head of Sustainable Investing</td>
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<tr>
<td>Canada Pension Plan Investment Board</td>
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<tr>
<td><strong>Eloy Lindeijer</strong></td>
</tr>
<tr>
<td>Chief, Investment Management, member Executive Committee</td>
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<td>PGGM</td>
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### Members (continued)

<table>
<thead>
<tr>
<th>Name</th>
<th>Role/Company</th>
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<tbody>
<tr>
<td>Ruixia Liu</td>
<td>General Manager, Risk Department, Industrial and Commercial Bank of China</td>
</tr>
<tr>
<td>Giuseppe Ricci</td>
<td>Chief Refining and Marketing Officer, ENI</td>
</tr>
<tr>
<td>Andreas Spiegel</td>
<td>Head Group Sustainability Risk, Swiss Re</td>
</tr>
<tr>
<td>Fiona Wild</td>
<td>Vice President, Sustainability and Climate Change, BHP Billiton</td>
</tr>
<tr>
<td>Jon Williams</td>
<td>Partner, Sustainability and Climate Change, PWC</td>
</tr>
<tr>
<td>Masaaki Nagamura</td>
<td>Head, Corporate Social Responsibility, Tokio Marine Holdings</td>
</tr>
<tr>
<td>Martin Skancke</td>
<td>Chair, Risk Committee, Storebrand</td>
</tr>
<tr>
<td>Steve Waygood</td>
<td>Chief Responsible Investment Officer, Aviva Investors</td>
</tr>
<tr>
<td>Michael Wilkins</td>
<td>Managing Director, Environmental &amp; Climate Risk Research, S&amp;P Global Ratings</td>
</tr>
<tr>
<td>Deborah Winshel</td>
<td>Managing Director, Global Head of Impact Investing, BlackRock</td>
</tr>
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### Special Adviser

<table>
<thead>
<tr>
<th>Name</th>
<th>Role/Company</th>
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<tbody>
<tr>
<td>Russell Picot</td>
<td>Chair, Audit and Risk Committee, LifeSight, Board Chair, HSBC Bank (UK) Pension Scheme Trustee, Former Group Chief Accounting Officer, HSBC</td>
</tr>
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</table>

### Secretariat

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<tr>
<th>Name</th>
<th>Role/Company</th>
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<tbody>
<tr>
<td>Mary Schapiro</td>
<td>Former Chair, U.S. Securities and Exchange Commission</td>
</tr>
<tr>
<td>Curtis Ravenel</td>
<td>Global Head, Sustainable Business &amp; Finance, Bloomberg LP</td>
</tr>
<tr>
<td>Stacy Coleman</td>
<td>Managing Director, Promontory Financial Group, an IBM Company</td>
</tr>
<tr>
<td>Mara Childress</td>
<td>Principal, Promontory Financial Group, an IBM Company</td>
</tr>
<tr>
<td>Didem Nisanci</td>
<td>Managing Director, Promontory Financial Group, an IBM Company</td>
</tr>
<tr>
<td>Jeff Stehm</td>
<td>Director, Promontory Financial Group, an IBM Company</td>
</tr>
<tr>
<td>Veronika Henze</td>
<td>Head of Communications, Bloomberg New Energy Finance</td>
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### Observers

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<tr>
<th>Name</th>
<th>Role/Company</th>
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<tbody>
<tr>
<td>Susan Nash</td>
<td>Member of Secretariat, Financial Stability Board</td>
</tr>
<tr>
<td>Joe Perry</td>
<td>Member of Secretariat, Financial Stability Board</td>
</tr>
<tr>
<td>Rupert Thorne</td>
<td>Deputy to the Secretary General, Financial Stability Board</td>
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Appendix 2: Task Force Objectives and Approach

1. Objectives
The Task Force engaged with key stakeholders throughout the development of its recommendations to ensure that its work would (1) promote alignment across existing disclosure regimes, (2) consider the perspectives of users and the concerns of preparers of climate-related financial disclosures, and (3) be efficiently implemented by organizations in their financial reporting.

2. Approach
In addition to the expertise of its members, a broad range of external resources informed the Task Force's recommendations, including existing voluntary and mandatory climate-related reporting frameworks, governance and risk management standards, government reports and research, expert resources, and various other stakeholders such as industry participants, trade associations, and non-governmental organizations (NGOs).

a. Leveraging Expertise
Task Force members come from a range of companies, including large financial companies, large non-financial companies, accounting and consulting firms, and credit rating agencies, and brought a range of practical experience, expertise, and global perspectives on preparing and using climate-related financial disclosures. Through eight plenary meetings, Task Force members contributed significantly to developing a consensus-based, industry-led approach to climate-related financial disclosure.

Due to the technically challenging and broad focus of its work, the Task Force also sought input from experts in the field of climate change, particularly in relation to scenario analysis. The Task Force engaged Environmental Resources Management (ERM) to inform its work by developing a technical paper on scenario analysis—The Use of Scenario Analysis in Disclosure of Climate-Related Risks and Opportunities. Several members of the Task Force, joined by representatives from 2° Investing Initiative (2°ii), Bloomberg New Energy Finance (BNEF), Bloomberg Quantitative Risk Experts, Carbon Tracker, CDP, and the London School of Economics and Political Science led a working group to oversee ERM's technical considerations. A workshop was also held with experts from Oxford Martin School. Additionally, the International Energy Agency (IEA) provided input regarding how scenario analysis can be conducted and used.

b. Research and Information Gathering
The Task Force's work drew on publications and research conducted by governments, NGOs, industry participants, as well as disclosure regimes with a focus on climate-related issues. The Task Force reviewed existing mandatory and voluntary reporting regimes for climate-related disclosure to identify commonalities and gaps across existing regimes and to determine areas meriting further research and analysis by the Task Force. The work of organizations regarded as standard setters, as well as several organizations active in developing reporting mechanisms for climate-related issues, served as the primary references for the Task Force in developing its recommendations and supporting guidance. The Task Force also considered resources related to sector-specific climate issues in the development of the supplemental guidance.
c. Outreach and Engagement

Engagement with users, preparers, and other stakeholders in relevant industries and sectors across G20 countries and other countries was important in developing the Task Force’s recommendations. The Task Force conducted five types of engagement to support this effort: public consultation, industry interviews, focus groups, outreach events, and webinars.

Such engagement served two primary purposes: (1) to raise the level of awareness and educate stakeholders on the Task Force’s work and (2) to solicit feedback from stakeholders on the Task Force’s proposed recommended disclosures and supplemental guidance for specific sectors. In total, more than 2,700 individuals in 43 countries were included in the Task Force’s outreach and engagement (Figure A2.1).

Public Consultations

The Task Force conducted two public consultations. The first followed the April 1, 2016 publication of the Task Force’s Phase I Report, which set out the scope and high-level objectives for the Task Force’s work. The Task Force solicited input to guide the development of its recommendations for voluntary climate-related financial disclosures. In total, 203 participants from 24 countries responded to the first public consultation. Respondents represented the financial sector, non-financial sectors, NGOs, and other organizations. Public consultation comments indicated support for disclosures on scenario analysis as well as disclosures tailored for specific sectors. Key themes from the first public consultation, which informed the Task Force’s recommendations and guidance, are included in Table A2.1 (p. 48).
A second public consultation followed the release of the Task Force's report in December 2016. The Task Force conducted the second consultation through an online questionnaire designed to gather feedback on the recommendations, guidance, and key issues identified by the Task Force. The Task Force received 306 responses to its online questionnaire and 59 comment letters on the recommendations and guidance from a variety of organizations in 30 countries. The majority of responses came from Europe (57 percent), followed by North America (20 percent), Asia Pacific (19 percent), South America (four percent), and the Middle East/Africa (less than one percent). Forty-five percent of respondents provided perspective as users of disclosure, 44 percent as preparers of disclosure, and 11 percent as "other." Respondents came from the financial sector (43 percent), non-financial sectors (18 percent), or other types of organizations (39 percent).

Table A2.2

Responses to Second Public Consultation Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Respondent</th>
<th>Percent Responding “Useful”</th>
</tr>
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<tbody>
<tr>
<td>How useful are the recommendations and guidance for all sectors in preparing disclosures?</td>
<td>Preparers</td>
<td>75%</td>
</tr>
<tr>
<td>How useful is the supplemental guidance in preparing disclosures?</td>
<td>Preparers</td>
<td>66%</td>
</tr>
<tr>
<td>If organizations disclose the recommended information, how useful would it be for decision making?</td>
<td>Users</td>
<td>77%</td>
</tr>
<tr>
<td>How useful is a description of potential performance across a range of scenarios to understanding climate-related impacts on an organization's businesses, strategy, and financial planning?</td>
<td>Financial</td>
<td>74%</td>
</tr>
<tr>
<td></td>
<td>Non-Financial</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>86%</td>
</tr>
<tr>
<td>How useful are the illustrative examples of metrics and targets?</td>
<td>Financial</td>
<td>74%</td>
</tr>
<tr>
<td></td>
<td>Non-Financial</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>72%</td>
</tr>
<tr>
<td>How useful would the disclosure of GHG emissions associated with investments be for economic decision-making?</td>
<td>Financial</td>
<td>68%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>74%</td>
</tr>
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</table>

61 Of the 59 respondents that submitted comment letters, 45 also completed the online questionnaire, resulting in a total of 320 unique responses.

62 The other types of organizations included research and advocacy NGOs; standard setting NGOs; data analytics, consulting, and research organizations; academia; and accounting associations.
Overall, respondents were generally supportive of the Task Force's recommendations as shown in Table A2.2 (p. 48); however, several provided specific and constructive feedback on the report. The key themes from this feedback are included in Table A2.3. For additional information regarding the results of the second public consultation, please view the TCFD Public Consultation Summary 2017 on the Task Force's website.

<table>
<thead>
<tr>
<th>Key Themes</th>
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<tbody>
<tr>
<td>Materiality and Location of Disclosures</td>
<td>Clarifying which recommended disclosures depend on materiality assessment and providing flexibility for organizations to provide some or all disclosures in reports other than financial filings.</td>
</tr>
<tr>
<td>Scenario Analysis</td>
<td>Improving ease of implementation, and comparability of scenario analysis by specifying standard scenario(s) and providing additional guidance and tools.</td>
</tr>
<tr>
<td>Metrics for the Financial Sector</td>
<td>Encouraging further development and standardization of metrics for the financial sector.</td>
</tr>
<tr>
<td>Metrics for Non-Financial Sectors</td>
<td>Improving comparability and consistency of the illustrative metrics for non-financial sectors, clarifying the links to financial impact and climate-related risks and opportunities.</td>
</tr>
<tr>
<td>Implementation</td>
<td>Providing disclosure examples to support preparers in developing relevant climate-related financial disclosures.</td>
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**Industry Interviews and Focus Groups**

Prior to the December 2016 release of the Task Force's report for public consultation, the Task Force conducted 128 industry interviews with users and preparers of financial statements to gather feedback regarding the Task Force's draft recommendations, supplemental guidance for certain sectors, and other considerations. Industry interview participants included chief financial officers, investment officers, other finance and accounting officers, risk officers, sustainability officers, and others. Forty-three percent of the participants held finance, legal, or risk positions and 39 percent held environmental or sustainability roles.

Task Force representatives conducted two rounds of industry interviews. The initial round of interviews focused on the recommendations and guidance; the second round emphasized specific recommendations and sector-specific guidance. Organizations invited to participate in the interviews met two primary criteria: (1) represented industry and sector leaders likely to be impacted by climate-related risks and opportunities and (2) provided geographic diversity to ensure coverage from each G20 and Financial Stability Board (FSB) represented country.

The interviews provided valuable information that informed the Task Force's recommendations and guidance as reflected in the report issued for public consultation in December 2016. Industry interview themes were consistent with those identified in the second public consultation. Preparers raised concerns about the relationship of the Task Force's recommendations to other reporting initiatives and the accuracy and reliability of information requested. Users commented that establishing consistency in metrics would be beneficial, acknowledged data quality challenges, and provided thoughts on scenario analysis (e.g., would like preparers to use of a range of scenarios, interested in knowing how scenario analysis is used in the organization).

Subsequent to the December 2016 release of the Task Force's report for public consultation, the Task Force conducted five focus groups with 32 individuals from six countries representing organizations in specific sectors and industries to solicit feedback on scenario analysis and carbon footprinting metrics. In the two focus groups for the financial sector, participants expressed support for the Task Force's work, noting current challenges related to quality and consistency in
reported climate-related information. Asset owners and asset managers also provided feedback on the benefits and limitations of different carbon footprinting metrics. In the three focus groups for non-financial sectors, participants in oil and gas and utilities industries provided specific feedback on their use of scenario analysis and challenges related to disclosing certain information in financial filings.

**Outreach Events**

The Task Force sponsored 18 public outreach events in 13 countries, and Task Force members presented the recommendations at 91 other events including conferences, forums, and meetings sponsored by industry associations, NGOs, government agencies, corporations, and other organizations. The 18 Task Force-sponsored events informed stakeholders of the Task Force's work and recommendations and included panel discussions and keynote speeches by prominent climate-risk and financial experts. Attendees included representatives of financial and non-financial organizations who spanned a variety of corporate functions, including strategy, risk, accounting, portfolio and investment management, corporate sustainability, as well as representatives from industry associations, NGOs, government agencies, research providers, academia, accounting and consulting firms, and media.

**Webinars**

Prior to the release of the report in December 2016 for public consultation, the Task Force offered seven webinars to educate and increase awareness of the Task Force's efforts as well as to collect additional feedback. Of the seven webinars, the Task Force hosted four webinars and participated in three additional webinars by partnering with the following organizations: Business for Social Responsibility, Global Financial Markets Association, and the National Association of Corporate Directors. These webinars served to supplement the in-person outreach events and offered global stakeholders, regardless of location, an opportunity to engage with the Task Force. The webinars included 538 attendees representing 365 organizations across 23 countries. After the release of the report, the Task Force held three webinars to present its recommendations and to solicit additional feedback. The three webinars included 255 attendees representing 209 organizations across 25 countries. In total, the Task Force offered ten webinars, reaching 793 attendees across 30 countries.
Appendix 3: Fundamental Principles for Effective Disclosure

To underpin its recommendations and help guide current and future developments in climate-related financial reporting, the Task Force developed a set of principles for effective disclosure.\(^{63}\) As understanding of, and approaches to, climate-related issues evolve over time, so too will climate-related financial reporting. These principles can help achieve high-quality and decision-useful disclosures that enable users to understand the impact of climate change on organizations. The Task Force encourages organizations adopting its recommendations to consider these principles as they develop climate-related financial disclosures.

The Task Force’s disclosure principles are largely consistent with other mainstream, internationally accepted frameworks for financial reporting and are generally applicable to most providers of financial disclosures. They are informed by the qualitative and quantitative characteristics of financial information and further the overall goals of producing disclosures that are consistent, comparable, reliable, clear, and efficient, as highlighted by the FSB in establishing the Task Force. The principles, taken together, are designed to assist organizations in making clear the linkages and connections between climate-related issues and their governance, strategy, risk management, and metrics and targets.

Principle 1: Disclosures should present relevant information

The organization should provide information specific to the potential impact of climate-related risks and opportunities on its markets, businesses, corporate or investment strategy, financial statements, and future cash flows.

- Disclosures should be eliminated if they are immaterial or redundant to avoid obscuring relevant information. However, when a particular risk or issue attracts investor and market interest or attention, it may be helpful for the organization to include a statement that the risk or issue is not significant. This shows that the risk or issue has been considered and has not been overlooked.

- Disclosures should be presented in sufficient detail to enable users to assess the organization’s exposure and approach to addressing climate-related issues, while understanding that the type of information, the way in which it is presented, and the accompanying notes will differ between organizations and will be subject to change over time.

- Climate-related impacts can occur over the short, medium, and long term. Organizations can experience chronic, gradual impacts (such as impacts due to shifting temperature patterns), as well as acute, abrupt disruptive impacts (such as impacts from flooding, drought, or sudden regulatory actions). An organization should provide information from the perspective of the potential impact of climate-related issues on value creation, taking into account and addressing the different time frames and types of impacts.

- Organizations should avoid generic or boilerplate disclosures that do not add value to users’ understanding of issues. Furthermore, any proposed metrics should adequately describe or serve as a proxy for risk or performance and reflect how an organization manages the risk and opportunities.

\(^{63}\) These principles are adapted from those included in the Enhanced Disclosure Task Force’s “Enhancing the Risk Disclosures of Banks.”
Principle 2: Disclosures should be specific and complete

- An organization's reporting should provide a thorough overview of its exposure to potential climate-related impacts; the potential nature and size of such impacts; the organization's governance, strategy, processes for managing climate-related risks, and performance with respect to managing climate-related risks and opportunities.

- To be sufficiently comprehensive, disclosures should contain historical and future-oriented information in order to allow users to evaluate their previous expectations relative to actual performance and assess possible future financial implications.

- For quantitative information, the disclosure should include an explanation of the definition and scope applied. For future-oriented data, this includes clarification of the key assumptions used. Forward-looking quantitative disclosure should align with data used by the organization for investment decision making and risk management.

- Any scenario analyses should be based on data or other information used by the organization for investment decision making and risk management. Where appropriate, the organization should also demonstrate the effect on selected risk metrics or exposures to changes in the key underlying methodologies and assumptions, both in qualitative and quantitative terms.

Principle 3: Disclosures should be clear, balanced, and understandable

- Disclosures should be written with the objective of communicating financial information that serves the needs of a range of financial sector users (e.g., investors, lenders, insurers, and others). This requires reporting at a level beyond compliance with minimum requirements. The disclosures should be sufficiently granular to inform sophisticated users, but should also provide concise information for those who are less specialized. Clear communication will allow users to identify key information efficiently.

- Disclosures should show an appropriate balance between qualitative and quantitative information and use text, numbers, and graphical presentations as appropriate.

- Fair and balanced narrative explanations should provide insight into the meaning of quantitative disclosures, including the changes or developments they portray over time. Furthermore, balanced narrative explanations require that risks as well as opportunities be portrayed in a manner that is free from bias.

- Disclosures should provide straightforward explanations of issues. Terms used in the disclosures should be explained or defined for a proper understanding by the users.

Principle 4: Disclosures should be consistent over time

- Disclosures should be consistent over time to enable users to understand the development and/or evolution of the impact of climate-related issues on the organization's business. Disclosures should be presented using consistent formats, language, and metrics from period to period to allow for inter-period comparisons. Presenting comparative information is preferred; however, in some situations it may be preferable to include a new disclosure even if comparative information cannot be prepared or restated.

- Changes in disclosures and related approaches or formats (e.g., due to shifting climate-related issues and evolution of risk practices, governance, measurement methodologies, or accounting practices) can be expected due to the relative immaturity of climate-related disclosures. Any such changes should be explained.
Principle 5: Disclosures should be comparable among organizations within a sector, industry, or portfolio

- Disclosures should allow for meaningful comparisons of strategy, business activities, risks, and performance across organizations and within sectors and jurisdictions.
- The level of detail provided in disclosures should enable comparison and benchmarking of risks across sectors and at the portfolio level, where appropriate.
- The placement of reporting would ideally be consistent across organizations—i.e., in financial filings—in order to facilitate easy access to the relevant information.

Principle 6: Disclosures should be reliable, verifiable, and objective

- Disclosures should provide high-quality reliable information. They should be accurate and neutral—i.e., free from bias.
- Future-oriented disclosures will inherently involve the organization’s judgment (which should be adequately explained). To the extent possible, disclosures should be based on objective data and use best-in-class measurement methodologies, which would include common industry practice as it evolves.
- Disclosures should be defined, collected, recorded, and analyzed in such a way that the information reported is verifiable to ensure it is high quality. For future-oriented information, this means assumptions used can be traced back to their sources. This does not imply a requirement for independent external assurance; however, disclosures should be subject to internal governance processes that are the same or substantially similar to those used for financial reporting.

Principle 7: Disclosures should be provided on a timely basis

- Information should be delivered to users or updated in a timely manner using appropriate media on, at least, an annual basis within the mainstream financial report.
- Climate-related risks can result in disruptive events. In case of such events with a material financial impact, the organization should provide a timely update of climate-related disclosures as appropriate.

Reporters may encounter tension in the application of the fundamental principles set out above. For example, an organization may update a methodology to meet the comparability principle, which could then result in a conflict with the principle of consistency. Tension can also arise within a single principle. For example, Principle 6 states that disclosures should be verifiable, but assumptions made about future-oriented disclosures often require significant judgment by management that is difficult to verify. Such tensions are inevitable given the wide-ranging and sometimes competing needs of users and preparers of disclosures. Organizations should aim to find an appropriate balance of disclosures that reasonably satisfy the recommendations and principles while avoiding overwhelming users with unnecessary information.
Appendix 4: Select Disclosure Frameworks

To the extent there is corporate reporting of climate-related issues, it happens through a multitude of mandatory and voluntary schemes. Although a complete and comprehensive survey of existing schemes is beyond the scope of this report, the Task Force on Climate-related Financial Disclosures (TCFD or Task Force) considered a broad range of existing frameworks, both voluntary and mandatory. The tables in Appendix 4 outline select disclosure frameworks considered by the Task Force and describe a few key characteristics of each framework, including whether disclosures are mandatory or voluntary, what type of information is reported, who the target reporters and target audiences are, where the disclosed information is placed, and whether there are specified materiality standards. These disclosure frameworks were chosen to illustrate the broad range of disclosure regimes around the world; the tables are broken out into disclosure frameworks sponsored by governments, stock exchanges, and non-governmental organizations (NGOs).


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These tables were originally included in the Task Force's Phase I Report and have been updated where appropriate.
### Table A4.1

<table>
<thead>
<tr>
<th>Region: Framework</th>
<th>Target Reporter</th>
<th>Target Audience</th>
<th>Mandatory or Voluntary</th>
<th>Materiality Standard</th>
<th>Types of Climate-Related Information</th>
<th>Disclosure Location</th>
<th>External Assurance Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Australia:</strong> National Greenhouse and Energy Reporting Act (2007)</td>
<td>Financial and non-financial firms that meet emissions or energy production or consumption thresholds</td>
<td>General public</td>
<td>Mandatory if thresholds are met</td>
<td>Based on emissions above a certain threshold</td>
<td>GHG emissions, energy consumption, and energy production</td>
<td>Report to government</td>
<td>Regulator may, by written notice to corporation, require an audit of its disclosures</td>
</tr>
<tr>
<td><strong>European Union (EU): EU Directive 2014/95 regarding disclosure of non-financial and diversity information (2014)</strong></td>
<td>Financial and non-financial firms that meet size criteria (i.e., have more than 500 employees)</td>
<td>Investors, consumers, and other stakeholders</td>
<td>Mandatory; applicable for the financial year starting on Jan. 1, 2017 or during the 2017 calendar year</td>
<td>None specified</td>
<td>Land use, water use, GHG emissions, use of materials, and energy use</td>
<td>Corporate financial report or separate report (published with financial report or on website six months after the balance sheet date and referenced in financial report)</td>
<td>Member States must require that statutory auditor checks whether the non-financial information in the non-financial statement has been provided. Member States may require independent assurance for information in the non-financial statement</td>
</tr>
<tr>
<td><strong>France:</strong> Article 173, Energy Transition Law (2015)</td>
<td>Listed financial and non-financial firms</td>
<td>Investors, general public</td>
<td>Mandatory</td>
<td>None specified</td>
<td>Risks related to climate change, consequences of climate change on the company’s activities and use of goods and services it produces. Institutional investors: GHG emissions and contribution to goal of limiting global warming</td>
<td>Annual report and website</td>
<td>Mandatory review on the consistency of the disclosure by an independent third party, such as a statutory auditor</td>
</tr>
<tr>
<td><strong>India:</strong> National Voluntary Guidelines on Social, Environmental, and Economic Responsibilities of Business (2011)</td>
<td>Financial and non-financial firms</td>
<td>Investors, general public</td>
<td>Voluntary</td>
<td>None specified</td>
<td>Significant risk, goals and targets for improving performance, materials, energy consumption, water, discharge of effluents, GHG emissions, and biodiversity</td>
<td>Not specified; companies may furnish a report or letter from owner/chief executive officer</td>
<td>Guidelines include third-party assurance as a “leadership indicator” of company’s progress in implementing the principles</td>
</tr>
</tbody>
</table>
Table A4.1

Select Disclosure Frameworks: Governments (continued)

<table>
<thead>
<tr>
<th>Region: Framework</th>
<th>Target Reporter</th>
<th>Target Audience</th>
<th>Mandatory or Voluntary</th>
<th>Materiality Standard</th>
<th>Types of Climate-Related Information</th>
<th>Disclosure Location</th>
<th>External Assurance Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom: Companies Act 2006 (Strategic Report and Directors' Report) Regulations 2013</td>
<td>Financial and non-financial firms that are “Quoted Companies,” as defined by the Companies Act 2006</td>
<td>Investors / shareholders (&quot;members of the company&quot;)</td>
<td>Mandatory</td>
<td>Information is material if its omission or misrepresentation could influence the economic decisions shareholders take on the basis of the annual report as a whole (section 5 of the UK FRC June 2014 Guidance on the Strategic Report)</td>
<td>The main trends and factors likely to affect the future development, performance, and position of the company's business, environmental matters (including the impact of the company's business on the environment), and GHG emissions</td>
<td>Strategic Report and Directors' Report</td>
<td>Not required, but statutory auditor must state in report on the company's annual accounts whether in the auditor's opinion the information given in the Strategic Report and the Directors' Report for the financial year for which the accounts are prepared is consistent with those accounts</td>
</tr>
<tr>
<td>United States: NAICs, 2010 Insurer Climate Risk Disclosure Survey</td>
<td>Insurers meeting certain premium thresholds - $100M in 2015</td>
<td>Regulators</td>
<td>Mandatory if thresholds are met</td>
<td>None specified</td>
<td>General disclosures about climate change-related risk management and investment management</td>
<td>Survey sent to state regulators</td>
<td>Not specified</td>
</tr>
<tr>
<td>United States: SEC Guidance Regarding Disclosure Related to Climate Change</td>
<td>Financial and non-financial firms subject to Securities and Exchange Commission (SEC) reporting requirements</td>
<td>Investors</td>
<td>Mandatory</td>
<td>US securities law definition</td>
<td>Climate-related material risks and factors that can affect or have affected the company's financial condition, such as regulations, treaties and agreements, business trends, and physical impacts</td>
<td>Annual and other reports required to be filed with SEC</td>
<td>Depends on assurance requirements for information disclosed</td>
</tr>
<tr>
<td>Region: Framework</td>
<td>Target Reporter</td>
<td>Target Audience</td>
<td>Mandatory or Voluntary</td>
<td>Materiality Standard</td>
<td>Types of Climate-Related Information</td>
<td>Disclosure Location</td>
<td>External Assurance Required</td>
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<tr>
<td>Australia: Australia Securities Exchange</td>
<td>Listed financial and non-financial firms</td>
<td>Investors</td>
<td>Mandatory (comply or explain)</td>
<td>A real possibility that the risk in question could substantively impact the listed entity's ability to create or preserve value for security holders over the short, medium or long term</td>
<td>General disclosure of material environmental risks</td>
<td>Annual report must include either the corporate governance statement or company website link to the corporate governance statement on company’s website</td>
<td>Not specified, may depend on assurance requirements for annual report</td>
</tr>
<tr>
<td>Brazil: Stock Exchange (BM&amp;F/Bovespa) Recommendation of report or explain (2012)</td>
<td>Listed financial and non-financial firms</td>
<td>Investors, regulator</td>
<td>Voluntary (comply or explain)</td>
<td>Criteria explained in Reference Form (Annex 24) of the Instruction CVM nº 480/09</td>
<td>Social and environmental information including methodology used, if audited/reviewed by an independent entity, and link to information (i.e., webpage)</td>
<td>Discretion of company</td>
<td>Not specified</td>
</tr>
<tr>
<td>China: Shenzhen Stock Exchange Social Responsibility Instructions to Listed Companies (2006)</td>
<td>Listed financial and non-financial firms</td>
<td>Investors</td>
<td>Voluntary: social responsibilities Mandatory: pollutant discharge</td>
<td>None specified</td>
<td>Waste generation, resource consumption, and pollutants</td>
<td>Not specified</td>
<td>Not specified; companies shall allocate dedicated human resources for regular inspection of implementation of environmental protection policies</td>
</tr>
</tbody>
</table>
Table A4.2

Select Disclosure Frameworks: Exchange Listing Requirements and Indices (continued)

<table>
<thead>
<tr>
<th>Region: Framework</th>
<th>Target Reporter</th>
<th>Target Audience</th>
<th>Mandatory or Voluntary</th>
<th>Materiality Standard</th>
<th>Types of Climate-Related Information</th>
<th>Disclosure Location</th>
<th>External Assurance Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa: Johannesburg Stock Exchange</td>
<td>Listed financial and non-financial firms</td>
<td>Investors</td>
<td>Mandatory; (comply or explain)</td>
<td>None specified</td>
<td>General disclosure regarding sustainability performance</td>
<td>Annual report</td>
<td>Required</td>
</tr>
<tr>
<td>World, regional, and country-specific indices: S&amp;P Dow Jones Indices Sustainability Index, Sample Questionnaires</td>
<td>Financial and non-financial firms</td>
<td>Investors</td>
<td>Voluntary</td>
<td>None specified</td>
<td>GHG emissions, SOx emissions, energy consumption, water, waste generation, environmental violations, electricity purchased, biodiversity, and mineral waste management</td>
<td>Nonpublic</td>
<td>Disclose whether external assurance was provided and whether it was pursuant to a recognized standard</td>
</tr>
</tbody>
</table>
### Table A4.3

**Select Disclosure Frameworks: Non-Governmental Organizations**

<table>
<thead>
<tr>
<th>Framework</th>
<th>Target Reporter</th>
<th>Target Audience</th>
<th>Mandatory or Voluntary</th>
<th>Materiality Standard</th>
<th>Types of Climate-Related Information</th>
<th>Disclosure Location</th>
<th>External Assurance Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Global:</strong> Asset Owners Disclosure Project, 2017 Global Climate Risk Survey</td>
<td>Pension funds, insurers, sovereign wealth funds &gt;2bn AUM</td>
<td>Asset managers, investment industry, government</td>
<td>Voluntary</td>
<td>None specified</td>
<td>Information on whether climate change issues are integrated in investment policies, engagement efforts, portfolio emissions intensity for scope 1 emissions, climate change-related portfolio risk mitigation actions</td>
<td>Survey responses; respondents are asked whether responses may be made public</td>
<td>Disclose whether external assurance was provided</td>
</tr>
<tr>
<td><strong>Global:</strong> CDP Annual Questionnaire (2016)</td>
<td>Financial and non-financial firms</td>
<td>Investors</td>
<td>Voluntary</td>
<td>None specified</td>
<td>Information on risk management procedures related to climate change risks and opportunities, energy use, and GHG emissions (Scope 1-3)</td>
<td>CDP database</td>
<td>Encouraged; information requested about verification and third party certification</td>
</tr>
<tr>
<td><strong>Global:</strong> CDSB Framework for Reporting Environmental Information &amp; Natural Capital</td>
<td>Financial and non-financial firms</td>
<td>Investors</td>
<td>Voluntary</td>
<td>Environmental information is material if (1) the environmental impacts or results it describes are, due to their size and nature, expected to have a significant positive or negative effect on the organization's current, past or future financial condition and operational results and its ability to execute its strategy or (2) omitting, misstating, or misinterpreting it could influence decisions that users of mainstream reports make about the organization</td>
<td>Environmental policies, strategy, and targets, including the indicators, plans, and timelines used to assess performance; material environmental risks and opportunities affecting the organization; governance of environmental policies, strategy, and information; and quantitative and qualitative results on material sources of environmental impact</td>
<td>Annual reporting packages in which organizations are required to deliver their audited financial results under the corporate, compliance or securities laws of the country in which they operate</td>
<td>Not required, but disclose if assurance has been provided over whether reported environmental information is in conformance with the CDSB Framework</td>
</tr>
<tr>
<td>Framework</td>
<td>Target Reporter</td>
<td>Target Audience</td>
<td>Mandatory or Voluntary</td>
<td>Materiality Standard</td>
<td>Types of Climate-Related Information</td>
<td>Disclosure Location</td>
<td>External Assurance Required</td>
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<tr>
<td>Global: CDSB Climate Change Reporting Framework, Ed. 1.1 (2012)</td>
<td>Financial and non-financial firms</td>
<td>Investors</td>
<td>Voluntary</td>
<td>Allow “investors to see major trends and significant events related to climate change that affect or have the potential to affect the company’s financial condition and/or its ability to achieve its strategy”</td>
<td>The extent to which performance is affected by climate-related risks and opportunities; governance processes for addressing those effects; exposure to significant climate-related issues; strategy or plan to address the issues; and GHG emissions</td>
<td>Annual reporting packages in which organizations are required to deliver their audited financial results under the corporate, compliance or securities laws of the territory or territories in which they operate</td>
<td>Not required unless International Standards on Auditing 720 requires the auditor of financial statements to read information accompanying them to identify material inconsistencies between the audited financial statements and accompanying information</td>
</tr>
<tr>
<td>Global: GRESB Infrastructure Asset Assessment &amp; Real Estate Assessment</td>
<td>Real estate asset/portfolio owners</td>
<td>Investors and industry stakeholders</td>
<td>Voluntary</td>
<td>None specified</td>
<td>Real estate sector-specific requirements related to fuel, energy, and water consumption and efficiencies as well as low-carbon products</td>
<td>Data collected through the GRESB Real Estate Assessment disclosed to participants themselves and: • for non-listed property funds and companies, to those of that company or fund’s investors that are GRESB Investor Members; • for listed real estate companies, to all GRESB Investor Members that invest in listed real estate securities.</td>
<td>Not required, but disclose whether external assurance was provided</td>
</tr>
<tr>
<td>Global: GRI Sustainability Reporting Standards (2016)</td>
<td>Organizations of any size, type, sector, or geographic location</td>
<td>All stakeholders</td>
<td>Voluntary</td>
<td>Topics that reflect the reporting organization’s significant economic, environmental, and social impacts or substantively influence the decisions of stakeholders</td>
<td>Materials, energy, water, biodiversity, emissions, effluents and waste, environmental compliance, and supplier environmental assessment</td>
<td>Stand-alone sustainability reports or annual reports or other published materials that include sustainability information</td>
<td>Not required, but advised</td>
</tr>
<tr>
<td>Framework</td>
<td>Target Reporter</td>
<td>Target Audience</td>
<td>Mandatory or Voluntary</td>
<td>Materiality Standard</td>
<td>Types of Climate-Related Information</td>
<td>Disclosure Location</td>
<td>External Assurance Required</td>
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<td><strong>Global:</strong></td>
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<tr>
<td>IIGCC</td>
<td>Oil and gas industries</td>
<td>Investors</td>
<td>Voluntary</td>
<td>None specified</td>
<td>GHG emissions and clean technologies data</td>
<td>Not specified</td>
<td>Not specified</td>
</tr>
<tr>
<td>Oil &amp; Gas (2010)</td>
<td>Automotive industry</td>
<td>Investors</td>
<td>Voluntary</td>
<td>None specified</td>
<td>GHG emissions and clean technologies data</td>
<td>Company's discretion</td>
<td>Not specified</td>
</tr>
<tr>
<td></td>
<td>Electric utilities</td>
<td>Investors</td>
<td>Voluntary</td>
<td>None specified</td>
<td>GHG emissions and electricity production</td>
<td>Company's discretion</td>
<td>Disclose how GHG emissions information was verified</td>
</tr>
<tr>
<td><strong>Global:</strong></td>
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<tr>
<td>IIRC</td>
<td>Public companies traded on international exchanges</td>
<td>Investors</td>
<td>Voluntary</td>
<td>Substantively affect the company's ability to create value over the short, medium, and long term</td>
<td>General challenges related to climate change, loss of ecosystems, and resource shortages</td>
<td>Standalone sustainability or integrated report</td>
<td>Not specified; discussion paper released on issues relating to assurance</td>
</tr>
<tr>
<td><strong>Global:</strong></td>
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<tr>
<td>IPIECA</td>
<td>Oil and gas industries</td>
<td>All stakeholders</td>
<td>Voluntary</td>
<td>Material sustainability issues are those that, in the view of company management and its external stakeholders, affect the company's performance or strategy and/or assessments or decisions about the company</td>
<td>Energy consumption</td>
<td>Sustainability reporting</td>
<td>Not required, but encouraged</td>
</tr>
<tr>
<td><strong>Global:</strong></td>
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<tr>
<td>PRI</td>
<td>Investors</td>
<td>Investors</td>
<td>Voluntary</td>
<td>None specified</td>
<td>Investor practices</td>
<td>Transparency report</td>
<td>Not specified</td>
</tr>
<tr>
<td><strong>United States:</strong></td>
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<tr>
<td>SASB</td>
<td>Public companies traded on US exchanges</td>
<td>Investors</td>
<td>Voluntary</td>
<td>A substantial likelihood that the disclosure of the omitted fact would have been viewed by the reasonable investor as having significantly altered the &quot;total mix&quot; of the information made available</td>
<td>Information on sustainability topics that are deemed material, standardized metrics tailored by industry</td>
<td>SEC filings</td>
<td>Depends on assurance requirements for information disclosed</td>
</tr>
</tbody>
</table>
Appendix 5: Glossary and Abbreviations

**Glossary**

**BOARD OF DIRECTORS (or BOARD)** refers to a body of elected or appointed members who jointly oversee the activities of a company or organization. Some countries use a two-tiered system where “board” refers to the “supervisory board” while “key executives” refers to the “management board.”

**CLIMATE-RELATED OPPORTUNITY** refers to the potential positive impacts related to climate change on an organization. Efforts to mitigate and adapt to climate change can produce opportunities for organizations, such as through resource efficiency and cost savings, the adoption and utilization of low-emission energy sources, the development of new products and services, and building resilience along the supply chain. Climate-related opportunities will vary depending on the region, market, and industry in which an organization operates.

**CLIMATE-RELATED RISK** refers to the potential negative impacts of climate change on an organization. Physical risks emanating from climate change can be event-driven (acute) such as increased severity of extreme weather events (e.g., cyclones, droughts, floods, and fires). They can also relate to longer-term shifts (chronic) in precipitation and temperature and increased variability in weather patterns (e.g., sea level rise). Climate-related risks can also be associated with the transition to a lower-carbon global economy, the most common of which relate to policy and legal actions, technology changes, market responses, and reputational considerations.

**FINANCIAL FILINGS** refer to the annual reporting packages in which organizations are required to deliver their audited financial results under the corporate, compliance, or securities laws of the jurisdictions in which they operate. While reporting requirements differ internationally, financial filings generally contain financial statements and other information such as governance statements and management commentary.

**FINANCIAL PLANNING** refers to an organization’s consideration of how it will achieve and fund its objectives and strategic goals. The process of financial planning allows organizations to assess future financial positions and determine how resources can be utilized in pursuit of short- and long-term objectives. As part of financial planning, organizations often create “financial plans” that outline the specific actions, assets, and resources (including capital) necessary to achieve these objectives over a 1-5 year period. However, financial planning is broader than the development of a financial plan as it includes long-term capital allocation and other considerations that may extend beyond the typical 3-5 year financial plan (e.g., investment, research and development, manufacturing, and markets).

**GOVERNANCE** refers to “the system by which an organization is directed and controlled in the interests of shareholders and other stakeholders.” Governance involves a set of relationships between an organization’s management, its board, its shareholders, and other stakeholders. Governance provides the structure and processes through which the objectives of the organization are set, progress against performance is monitored, and results are evaluated.

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GREENHOUSE GAS (GHG) EMISSIONS SCOPE LEVELS

- **Scope 1** refers to all direct GHG emissions.
- **Scope 2** refers to indirect GHG emissions from consumption of purchased electricity, heat, or steam.
- **Scope 3** refers to other indirect emissions not covered in Scope 2 that occur in the value chain of the reporting company, including both upstream and downstream emissions. Scope 3 emissions could include: the extraction and production of purchased materials and fuels, transport-related activities in vehicles not owned or controlled by the reporting entity, electricity-related activities (e.g., transmission and distribution losses), outsourced activities, and waste disposal.

**INTERNAL CARBON PRICE** is an internally developed estimated cost of carbon emissions. Internal carbon pricing can be used as a planning tool to help identify revenue opportunities and risks, as an incentive to drive energy efficiencies to reduce costs, and to guide capital investment decisions.

**MANAGEMENT** refers to those positions an organization views as executive or senior management positions and that are generally separate from the board.

**NATIONALLY DETERMINED CONTRIBUTION (NDC)** refers to the post-2020 actions that a country intends to take under the international climate agreement adopted in Paris.

**ORGANIZATION** refers to the group, company, or companies, and other entities for which consolidated financial statements are prepared, including subsidiaries and jointly controlled entities.

**PUBLICLY AVAILABLE 2°C SCENARIO** refers to a 2°C scenario that is (1) used/referenced and issued by an independent body; (2) wherever possible, supported by publicly available datasets; (3) updated on a regular basis; and (4) linked to functional tools (e.g., visualizers, calculators, and mapping tools) that can be applied by organizations. 2°C scenarios that presently meet these criteria include: IEA 2DS, IEA 450, Deep Decarbonization Pathways Project, and International Renewable Energy Agency.

**RISK MANAGEMENT** refers to a set of processes that are carried out by an organization's board and management to support the achievement of the organization's objectives by addressing its risks and managing the combined potential impact of those risks.

**SCENARIO ANALYSIS** is a process for identifying and assessing a potential range of outcomes of future events under conditions of uncertainty. In the case of climate change, for example, scenarios allow an organization to explore and develop an understanding of how the physical and transition risks of climate change may impact its businesses, strategies, and financial performance over time.

**SECTOR** refers to a segment of organizations performing similar business activities in an economy. A sector generally refers to a large segment of the economy or grouping of business types, while "industry" is used to describe more specific groupings of organizations within a sector.

**STRATEGY** refers to an organization's desired future state. An organization's strategy establishes a foundation against which it can monitor and measure its progress in reaching that desired state. Strategy formulation generally involves establishing the purpose and scope of the
organization's activities and the nature of its businesses, taking into account the risks and opportunities it faces and the environment in which it operates.

SUSTAINABILITY REPORT is an organizational report that gives information about economic, environmental, social, and governance performance and impacts. For companies and organizations, sustainability—the ability to be long-lasting or permanent—is based on performance and impacts in these four key areas.

VALUE CHAIN refers to the upstream and downstream life cycle of a product, process, or service, including material sourcing, production, consumption, and disposal/recycling. Upstream activities include operations that relate to the initial stages of producing a good or service (e.g., material sourcing, material processing, supplier activities). Downstream activities include operations that relate to processing the materials into a finished product and delivering it to the end user (e.g., transportation, distribution, and consumption).

Abbreviations

2°C —2° Celsius
ASC—Accounting Standards Codification
BNEF—Bloomberg New Energy Finance
CDSD—Climate Disclosure Standards Board
ERM—Environmental Resources Management
EU—European Union
FASB—Financial Accounting Standards Board
FSB—Financial Stability Board
G20—Group of 20
GHG—Greenhouse gas
GICS—Global Industry Classification Standard
GRI—Global Reporting Initiative
IAS—International Accounting Standard
IASB—International Accounting Standards Board
IEA—International Energy Agency
IIGCC—Institutional Investors Group on Climate Change
IIRC—International Integrated Reporting Council
IPCC—Intergovernmental Panel on Climate Change
NGO—Non-governmental organization
OECD—Organization for Economic Co-operation and Development
R&D—Research and development
SASB—Sustainability Accounting Standards Board
TCFD—Task Force on Climate-related Financial Disclosures
UN—United Nations
UNEP—United Nations Environment Programme
USDE—U.S. Dollar Equivalent
WRI—World Resources Institute
Appendix 6: References


APPENDIX B

A  Introduction

B  Climate-Related Risks, Opportunities, and Financial Impacts

C  Recommendations and Guidance

D  Scenario Analysis and Climate-Related Issues

E  Key Issues Considered and Areas for Further Work

F  Conclusion

Appendices
NAIC Climate Risk Disclosure Survey / TCFD Comparison
Lisa Groshong, PhD, CIPR communication research scientist, and Tyler Gerson, CIPR intern
March 2021

Introduction
The following comparisons of the NAIC climate risk disclosure survey and TCFD guidelines are built upon a framework of the CERES Scoring Framework (Insurer Climate Risk Disclosure Survey Report & Scorecard: 2016 Findings & Recommendations, p. 76). The CERES framework organized each NAIC survey question into an overarching theme. These themes are:

1. Climate governance
2. Enterprise-wide climate risk management
3. Climate change modeling & analytics
4. Stakeholder engagement
5. Internal greenhouse gas management

This comparison document incorporates the TCFD questions and NAIC subquestions into the CERES framework on three levels. In each comparison table, NAIC survey question numbers are listed in the far left column, along with a descriptive keyword assigned by CIPR. The question numbers and text are highlighted in blue. The TCFD question theme names and numbers are listed in the far right column. The question numbers and text are highlighted in yellow.

First, we constructed a high-level comparison that shows the relationship of the main, top-level questions from each survey to the overall CERES themes. Currently, qualifying U.S. insurers are only required to answer the eight main NAIC risk disclosure survey questions.

Second, we took a closer look at the TCFD’s clarifying subquestions. For this section, we retained the organization of the main NAIC risk disclosure survey questions and layered in the TCFD subquestions where they matched thematically. Subquestion letter designations (e.g., a, b, c) were added for clarity.

Finally, in the third section, we retained the previous comparison and added in the NAIC risk disclosure survey subquestions, matching them with the most relevant CERES theme and TCFD question or subquestion. Subquestion letter designations (e.g., a, b, c) were added for clarity.

The final section contains the complete list of NAIC climate risk disclosure survey questions and the TCFD questions, including supplementary TCFD questions specific to the insurance industry. The insurance supplementary questions can also be found on the TCFD website. They were not included in the analysis above.
High-level comparison of NAIC disclosures with TCFD guidelines

<table>
<thead>
<tr>
<th>NAIC Survey Question #</th>
<th>TCFD Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 1: Climate Governance</strong></td>
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<tr>
<td>2 Risk plan</td>
<td>Does the company have a climate change policy with respect to risk management and investment management?</td>
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<tr>
<td></td>
<td>Disclose the organization’s governance around climate-related risks and opportunities.</td>
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<tr>
<td><strong>Theme 2: Enterprise-Wide Climate Risk Management</strong></td>
<td></td>
</tr>
<tr>
<td>3 Assess</td>
<td>Describe your company’s process for identifying climate change-related risks and assessing the degree that they could affect your business, including financial implications.</td>
</tr>
<tr>
<td>4 Risks</td>
<td>Summarize the current or anticipated risks that climate change poses to your company. Explain the ways that these risks could affect your business. Include identification of the geographical areas affected by these risks.</td>
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<td>Disclose the actual and potential impacts of climate related risks and opportunities on the organization’s businesses, strategy and financial planning where such information is material.</td>
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<td></td>
<td>Disclose how the organization identifies, assesses, and manages climate-related risks.</td>
</tr>
<tr>
<td>5 Invest</td>
<td>Has the company considered the impact of climate change on its investment portfolio?</td>
</tr>
<tr>
<td><strong>Theme 3: Climate Change Modeling &amp; Analytics</strong></td>
<td></td>
</tr>
<tr>
<td>8 Manage</td>
<td>Describe actions the company is taking to manage the risks climate change poses to your business including, in general terms, the use of computer modeling.</td>
</tr>
<tr>
<td><strong>Theme 4: Stakeholder Engagement</strong></td>
<td></td>
</tr>
<tr>
<td>6 Mitigate</td>
<td>Summarize steps the company has taken to encourage policyholders to reduce the losses caused by climate change-influenced events.</td>
</tr>
<tr>
<td>7 Engage</td>
<td>Discuss steps, if any, the company has taken to engage key constituencies on the topic of climate change.</td>
</tr>
<tr>
<td><strong>Theme 5: Internal Greenhouse Gas Management</strong></td>
<td></td>
</tr>
<tr>
<td>1 Emissions</td>
<td>Does the company have a plan to assess, reduce or mitigate its emissions in its operations or organizations?</td>
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<tr>
<td></td>
<td>Disclose how the organization identifies, assesses, and manages climate-related risks.</td>
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</table>
Comparison of TCFD main & subquestions to NAIC main risk disclosure questions

A comprehensive comparison of TCFD’s alignment with several additional disclosure frameworks (as of 2017) is available at https://www.tcfdhub.org/alignment/

<table>
<thead>
<tr>
<th>NAIC Survey Question #</th>
<th>TCFD Theme &amp; Subquestion</th>
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<td><strong>Theme 1: Climate Governance</strong></td>
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<tr>
<td>Disclosure the organization’s governance around climate-related risks and opportunities.</td>
<td>Governance</td>
</tr>
<tr>
<td>Describe the board’s oversight of climate-related risks and opportunities.</td>
<td>Governance (a)</td>
</tr>
<tr>
<td>Describe management’s role in assessing and managing climate-related risks and opportunities.</td>
<td>Governance (b)</td>
</tr>
<tr>
<td><strong>Theme 2: Enterprise-Wide Climate Risk Management</strong></td>
<td></td>
</tr>
<tr>
<td>3 Assess</td>
<td>Describe your company’s process for identifying climate change-related risks and assessing the degree that they could affect your business, including financial implications.</td>
</tr>
<tr>
<td>Describe the organization’s processes for (a) identifying and assessing and (b) managing climate-related risks.</td>
<td>Risk management (a) and (b)</td>
</tr>
<tr>
<td>4 Risks</td>
<td>Summarize the current or anticipated risks that climate change poses to your company. Explain the ways that these risks could affect your business. Include identification of the geographical areas affected by these risks.</td>
</tr>
<tr>
<td>Disclose the actual and potential impacts of climate related risks and opportunities on the organization’s businesses, strategy and financial planning where such information is material.</td>
<td>Strategy</td>
</tr>
<tr>
<td>Disclose the climate-related risks and opportunities the organization has identified over the short, medium, and long term.</td>
<td>Strategy (a)</td>
</tr>
<tr>
<td>Disclose how the organization identifies, assesses, and manages climate-related risks.</td>
<td>Risk management</td>
</tr>
<tr>
<td>5 Invest</td>
<td>Has the company considered the impact of climate change on its investment portfolio?</td>
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<tr>
<td>Describe the impact of climate-related risks and opportunities on the organization’s business, strategy, and financial planning.</td>
<td>Strategy (b)</td>
</tr>
<tr>
<td>Describe how processes for identifying, assessing, and managing climate-related risks are integrated into the organization’s overall risk management.</td>
<td>Risk management (c)</td>
</tr>
</tbody>
</table>

**Theme 3: Climate Change Modeling & Analytics**
| **Theme 4: Stakeholder Engagement** |
| **6 Mitigate** | Summarize steps the company has taken to encourage policyholders to reduce the losses caused by climate change-influenced events. |
| **7 Engage** | Discuss steps, if any, the company has taken to engage key constituencies on the topic of climate change. |

| **Theme 5: Internal Greenhouse Gas Management** |
| **1 Emissions** | Does the company have a plan to assess, reduce or mitigate its emissions in its operations or organizations? |
| | Disclose Scope 1, Scope 2, and if appropriate, Scope 3 greenhouse gases emissions, and the related risks. | Metrics and targets (b) |
## Comprehensive comparison of NAIC and TCFD questions

A comprehensive comparison of TCFD’s alignment with several additional disclosure frameworks (as of 2017) is available at https://www.tcfdhub.org/alignment/

### NAIC Climate Risk Disclosure Survey / TCFD Comparison:

#### TCFD main & subquestions compared to NAIC survey


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<td>2 Risk plan</td>
<td>Does the company have a climate change policy with respect to risk management and investment management?</td>
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<tr>
<td>2a Where in the structure of the company is climate risk addressed?</td>
<td></td>
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<tr>
<td>2b Does the company approach climate change as an Enterprise Risk Management (ERM) issue?</td>
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</tr>
<tr>
<td>Disclose the organization’s governance around climate-related risks and opportunities.</td>
<td>Governance</td>
</tr>
<tr>
<td>2c Does the company have a dedicated point-person or team within the company that is responsible for managing its climate change strategy?</td>
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<tr>
<td>Describe the board’s oversight of climate-related risks and opportunities.</td>
<td>Governance (a)</td>
</tr>
<tr>
<td>2d What is the role of the board of directors in governing climate risk management?</td>
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<tr>
<td>Describe management’s role in assessing and managing climate-related risks and opportunities.</td>
<td>Governance (b)</td>
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<tr>
<td><strong>Theme 2: Enterprise-Wide Climate Risk Management</strong></td>
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<td>3 Assess</td>
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<tr>
<td>3a How may climate change shift customer demand for products?</td>
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</tr>
<tr>
<td>3b What implications may climate change have on liquidity and capital needs?</td>
<td></td>
</tr>
<tr>
<td>3c How might climate change affect limits, cost and terms of catastrophe reinsurance, including reinstatement provisions?</td>
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<td>3d Has the insurer considered creative methods of risk distribution such as contingency plans to reduce financial leverage and resolve any liquidity issues in the event of a sudden loss in surplus and cash outflows as a result of a catastrophic event?</td>
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<tr>
<td>3e How are these impacts likely to evolve over time? Does the company have plans to regularly reassess climate change related risks and its responses to those risks?</td>
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<tr>
<td>4 Risks</td>
<td>Summarize the current or anticipated risks that climate change poses to your company. Explain the ways that these risks could affect your business.</td>
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<tr>
<td>business. Include identification of the geographical areas affected by these risks.</td>
<td>Disclose the actual and potential impacts of climate related risks and opportunities on the organization’s businesses, strategy and financial planning where such information is material.</td>
</tr>
<tr>
<td>4b</td>
<td>What implications may climate change have on liquidity and capital needs?</td>
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<tr>
<td>4c</td>
<td>How might climate change affect limits, cost and terms of catastrophe reinsurance, including reinstatement provisions?</td>
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<td>4d</td>
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<tr>
<td>Disclose the climate-related risks and opportunities the organization has identified over the short, medium, and long term.</td>
<td>Strategy (a)</td>
</tr>
<tr>
<td>4e</td>
<td>How are these impacts [climate risks] likely to evolve over time? Does the company have plans to regularly reassess climate change related risks and its responses to those risks?</td>
</tr>
<tr>
<td>2e</td>
<td>Does the company consider potentially correlated risks affecting asset management and underwriting?</td>
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<td>6c</td>
<td>How might climate change affect limits, cost and terms of catastrophe reinsurance, including reinstatement provisions?</td>
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<td>4a</td>
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</tr>
<tr>
<td>5b</td>
<td>What implications may climate change have on liquidity and capital needs?</td>
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<tr>
<td>Describe the impact of climate-related risks and opportunities on the organization’s business, strategy, and financial planning.</td>
<td>Strategy (b)</td>
</tr>
<tr>
<td>6b</td>
<td>What implications may climate change have on liquidity and capital needs?</td>
</tr>
<tr>
<td>Describe how processes for identifying, assessing, and managing climate-related risks are integrated into the organization’s overall risk management.</td>
<td>Risk management (c)</td>
</tr>
</tbody>
</table>

**Theme 3: Climate Change Modeling & Analytics**

8 Manage | Describe actions the company is taking to manage the risks climate change poses to your business including, in general terms, the use of computer modeling. |   |
<table>
<thead>
<tr>
<th>Describe the resilience of the organization’s strategy, taking into consideration different climate-related scenarios, including a 2° C or lower scenario.</th>
<th>Strategy (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5e</strong> How are these impacts likely to evolve over time? Does the company have plans to regularly reassess climate change related risks and its responses to those risks?</td>
<td></td>
</tr>
<tr>
<td>Disclose the metrics used by the organization to assess climate-related risks and opportunities in line with its strategy and risk management process.</td>
<td>Metrics and targets (a)</td>
</tr>
<tr>
<td><strong>8a</strong> For what perils does the company believe that future trends may deviate substantially from historical trends due to changes in the hazard? Similarly, for what perils, if any, does the company believe that a catastrophe model extrapolating observed trends would be insufficient to plan for maximum possible loss or yearly average loss? What steps has the company taken to model or analyze perils associated with non-stationary hazards?</td>
<td></td>
</tr>
<tr>
<td><strong>8b</strong> Has the company used catastrophe models to conduct hypothetical “stress tests” to determine the implications of a wide range of plausible climate change scenarios? If so, over what timescale, in what geographies and for what perils?</td>
<td></td>
</tr>
<tr>
<td><strong>8c</strong> Has the company conducted, commissioned or participated in scenario modeling for climate trends beyond the 1-5 year timescale? If so, what conclusions did the company reach on the potential implications for insurability under these scenarios?</td>
<td></td>
</tr>
<tr>
<td>Describe the targets used by the organization to manage climate-related risks and opportunities and performance against targets.</td>
<td>Metrics and targets (c)</td>
</tr>
</tbody>
</table>

**Theme 4: Stakeholder Engagement**

**6 Mitigate** Summarize steps the company has taken to encourage policyholders to reduce the losses caused by climate change-influenced events.

**6a** How might climate change shift customer demand for products?

**7 Engage** Discuss steps, if any, the company has taken to engage key constituencies on the topic of climate change.

**7a** How has the company supported improved research and/or risk analysis on the impacts of climate change?

**7b** What resources has it invested to improve climate awareness among its customers in regulated and unregulated lines?

**7c** What steps has it taken to educate shareholders on potential climate change risks the company faces?

**2f** Has the company issued a public statement on its climate policy?

**Theme 5: Internal Greenhouse Gas Management**

**1 Emissions** Does the company have a plan to assess, reduce or mitigate its emissions in its operations or organizations?

Disclose Scope 1, Scope 2, and if appropriate, Scope 3 greenhouse gases emissions, and the related risks. | Metrics and targets (b)
### NAIC survey subquestions that do not fit neatly into the above

<table>
<thead>
<tr>
<th>Sa</th>
<th>How may climate change shift customer demand for products?</th>
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<tr>
<td>Sc</td>
<td>How might climate change affect limits, cost and terms of catastrophe reinsurance, including reinstatement provisions?</td>
</tr>
<tr>
<td>Sd</td>
<td>Has the insurer considered creative methods of risk distribution such as contingency plans to reduce financial leverage and resolve any liquidity issues in the event of a sudden loss in surplus and cash outflows as a result of a catastrophic event?</td>
</tr>
</tbody>
</table>
NAIC Climate Risk Disclosure Survey Questions

Full question and guidance document available at the California DOI website.

1. Does the company have a plan to assess, reduce or mitigate its emissions in its operations or organizations? If yes, please summarize.
2. Does the company have a climate change policy with respect to risk management and investment management? If yes, please summarize. If no, how do you account for climate change in your risk management?
   - Where in the structure of the company is climate risk addressed?
   - Does the company approach climate change as an Enterprise Risk Management (ERM) issue?
   - Does the company have a dedicated point-person or team within the company that is responsible for managing its climate change strategy?
   - What is the role of the board of directors in governing climate risk management?
   - Does the company consider potentially correlated risks affecting asset management and underwriting?
   - Has the company issued a public statement on its climate policy?

3. Describe your company’s process for identifying climate change-related risks and assessing the degree that they could affect your business, including financial implications.
   - How may climate change shift customer demand for products?
   - What implications may climate change have on liquidity and capital needs?
   - How might climate change affect limits, cost and terms of catastrophe reinsurance, including reinstatement provisions?
   - Has the insurer considered creative methods of risk distribution such as contingency plans to reduce financial leverage and resolve any liquidity issues in the event of a sudden loss in surplus and cash outflows as a result of a catastrophic event?
   - How are these impacts likely to evolve over time? Does the company have plans to regularly reassess climate change related risks and its responses to those risks?

4. Summarize the current or anticipated risks that climate change poses to your company. Explain the ways that these risks could affect your business. Include identification of the geographical areas affected by these risks.
   - How may climate change shift customer demand for products?
   - What implications may climate change have on liquidity and capital needs?
   - How might climate change affect limits, cost and terms of catastrophe reinsurance, including reinstatement provisions?
   - Has the insurer considered creative methods of risk distribution such as contingency plans to reduce financial leverage and resolve any liquidity issues in the event of a sudden loss in surplus and cash outflows as a result of a catastrophic event?
   - How are these impacts likely to evolve over time? Does the company have plans to regularly reassess climate change related risks and its responses to those risks?

5. Part A: Has the company considered the impact of climate change on its investment portfolio? Part B: Has it altered its investment strategy in response to these considerations? If so, please summarize steps you have taken.
   - How may climate change shift customer demand for products?
   - What implications may climate change have on liquidity and capital needs?
   - How might climate change affect limits, cost and terms of catastrophe reinsurance, including reinstatement provisions?
6. Summarize steps the company has taken to encourage policyholders to reduce the losses caused by climate change-influenced events.
   - Has the insurer considered creative methods of risk distribution such as contingency plans to reduce financial leverage and resolve any liquidity issues in the event of a sudden loss in surplus and cash outflows as a result of a catastrophic event?
   - How are these impacts likely to evolve over time? Does the company have plans to regularly reassess climate change related risks and its responses to those risks?

7. Discuss steps, if any, the company has taken to engage key constituencies on the topic of climate change.
   - How has the company supported improved research and/or risk analysis on the impacts of climate change?
   - What resources has it invested to improve climate awareness among its customers in regulated and unregulated lines?
   - What steps has it taken to educate shareholders on potential climate change risks the company faces?

8. Describe actions the company is taking to manage the risks climate change poses to your business including, in general terms, the use of computer modeling. If Yes - Please summarize what actions the company is taking and in general terms the use if any of computer modeling in response text box.
   - For what perils does the company believe that future trends may deviate substantially from historical trends due to changes in the hazard? Similarly, for what perils, if any, does the company believe that a catastrophe model extrapolating observed trends would be insufficient to plan for maximum possible loss or yearly average loss? What steps has the company taken to model or analyze perils associated with non-stationary hazards?
   - Has the company used catastrophe models to conduct hypothetical “stress tests” to determine the implications of a wide range of plausible climate change scenarios? If so, over what timescale, in what geographies and for what perils?
   - Has the company conducted, commissioned or participated in scenario modeling for climate trends beyond the 1-5 year timescale? If so, what conclusions did the company reach on the potential implications for insurability under these scenarios?
TCFD Questions, including Insurance Supplements

Main TCFD Questions
From [https://live-tcfdhub.pantheonsite.io/](https://live-tcfdhub.pantheonsite.io/)

<table>
<thead>
<tr>
<th>Governance</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommended Disclosures</strong></td>
<td><strong>Recommended Disclosures</strong></td>
</tr>
<tr>
<td>a) Describe the board’s oversight of climate-related risks and opportunities.</td>
<td>a) Describe the climate-related risks and opportunities the organization has identified over the short, medium, and long term.</td>
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<td>b) Describe management’s role in assessing and managing climate-related risks and opportunities.</td>
<td>b) Describe the impact of climate-related risks and opportunities on the organization’s business, strategy, and financial planning.</td>
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<tr>
<td>c) Describe the resilience of the organization’s strategy, taking into consideration different climate-related scenarios, including a 2°C or lower scenario.</td>
<td>d) Describe the resilience of the organization’s strategy, including climate-related risks and opportunities where such information is material.</td>
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<th>Risk Management</th>
<th>Metrics and Targets</th>
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<tbody>
<tr>
<td><strong>Recommended Disclosures</strong></td>
<td><strong>Recommended Disclosures</strong></td>
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<tr>
<td>a) Describe the organization’s processes for identifying and assessing climate-related risks.</td>
<td>a) Disclose the metrics used by the organization to assess climate-related risks and opportunities in line with its strategy and risk management process.</td>
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<tr>
<td>b) Describe the organization’s processes for managing climate-related risks.</td>
<td>b) Disclose Scope 1, Scope 2, and if appropriate, Scope 3 greenhouse gas (GHG) emissions, and the related risks.</td>
</tr>
<tr>
<td>c) Describe how processes for identifying, assessing, and managing climate-related risks are integrated into the organization’s overall risk management.</td>
<td>d) Describe the targets used by the organization to manage climate-related risks and opportunities and performance against targets.</td>
</tr>
</tbody>
</table>
**Supplemental TCFD Guidance for Insurance Companies**

**Strategy (link to source document):**

**Supplement for Strategy (B) Describe the impact of climate-related risks and opportunities on the organization’s businesses, strategy, and financial planning.**

Insurance companies should describe the potential impacts of climate-related risks and opportunities, as well as provide supporting quantitative information where available, on their core businesses, products, and services, including:

- information at the business division, sector, or geography levels;
- how the potential impacts influence client, cedent, or broker selection; and
- whether specific climate-related products or competencies are under development, such as insurance of green infrastructure, specialty climate-related risk advisory services, and climate-related client engagement.

**Supplement for Strategy (C) Describe the resilience of the organisation’s strategy, taking into consideration different climate-related scenarios, including a 2°C or lower scenario.**

Insurance companies that perform climate-related scenario analysis on their underwriting activities should provide the following information:

- description of the climate-related scenarios used, including the critical input parameters, assumptions and considerations, and analytical choices. In addition to a 2°C scenario, insurance companies with substantial exposure to weather-related perils should consider using a greater than 2°C scenario to account for physical effects of climate change and
- time frames used for the climate-related scenarios, including short-, medium-, and long-term milestones.

**Risk Management (link to source document):**

**Supplement for Strategy (A) Describe the organization’s processes for identifying and assessing climate-related risks.**

Insurance companies should describe the processes for identifying and assessing climate-related risks on re-/insurance portfolios by geography, business division, or product segments, including the following risks:

- physical risks from changing frequencies and intensities of weather-related perils,
- transition risks resulting from a reduction in insurable interest due to a decline in value, changing energy costs, or implementation of carbon regulation, and
- liability risks that could intensify due to a possible increase in litigation.

**Supplement for Strategy (B) Describe the organization’s processes for managing climate-related risks.**

Insurance companies should describe key tools or instruments, such as risk models, used to manage climate-related risks in relation to product development and pricing.

Insurance companies should also describe the range of climate-related events considered and how the risks generated by the rising propensity and severity of insurance companies should also describe the range of...
climate-related events considered and how the risks generated by the rising propensity and severity of such events are managed such events are managed.

**Metrics and Targets (link to source document):**

**Supplement for Strategy (A)** Disclose the metrics used by the organization to assess climate-related risks and opportunities in line with its strategy and risk management process.

Insurance companies should provide aggregated risk exposure to weather-related catastrophes of their property business (i.e., annual aggregated expected losses from weather-related catastrophes) by relevant jurisdiction.
<table>
<thead>
<tr>
<th>Group ID</th>
<th>NAIC ID</th>
<th>Company Name</th>
<th>State Of Domicile</th>
<th>TCFD Filer</th>
<th>Group Survey Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>38733</td>
<td>2698</td>
<td>Alaska National Insurance Company</td>
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Attachment One
Climate and Resiliency (EX) Task Force
4/9/21

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GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

The Government Relations (EX) Leadership Council did not meet at the Spring National Meeting.
INNOVATION AND TECHNOLOGY (EX) TASK FORCE

Innovation and Technology (EX) Task Force April 9, 2021, Minutes ................................................................. 4-163
Big Data and Artificial Intelligence (EX) Task Force March 29, 2021, Minutes (Attachment One) ..................... 4-169
Speed to Market (EX) Working Group March 10, 2021, Minutes (Attachment Two) ........................................... 4-172
Request for Information (RFI) – Spring Follow-Up Summary Related to Continuing Specific “Regulatory Relief” or “Regulatory Accommodations” Offered by the States Related to the COVID-19 Pandemic (Attachment Three) ..................................................................................................... 4-175
The Innovation and Technology (EX) Task Force met April 9, 2021. The following Task Force members participated: Jon Godfread, Chair, and Chris Aufenthie (ND); Elizabeth Kelleher Dwyer, Vice Chair, and Matt Gendron (RI); Lori K. Wing-Heier, Anna Latham and Chris Murray (AK); Jim L. Ridling represented by Dan Gates, Gina Hunt and Jimmy Gunn (AL); Alan McClain represented by Letty Hardee (AR); Peni Itula Sapini Teo represented by Elizabeth Perri (AS); Evan G. Daniels represented by Tom Zuppan (AZ); Ricardo Lara represented by Ken Allen and Lucy Jabourian (CA); Michael Conway represented by Peg Brown and Eric Unger (CO); Andrew N. Mais and George Bradner (CT); Trinidad Navarro represented by Tim Li (DE); David Altmayer (FL); Colin M. Hayashida represented by Martha Im and Kathleen Nakasone (HI); Doug Ommen and Travis Grassel (IA); Dean L. Cameron and Weston Trexler (ID); Dana Popish Severinghaus and C.J. Metcalf (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt and LeAnn Crow (KS); Sharon P. Clark (KY); James J. Donelon represented by Rich Piazza and Tom Travis (LA); Gary D. Anderson and Rachel M. Davison (MA); Kathleen A. Birrane (MD); Eric A. Cioppa (ME); Anita G. Fox represented by Karen Dennis (MI); Grace Arnold, Tammy Lohmann and Phil Vigliaturo (MN); Chlora Lindley-Myers and Cynthia Amann (MO); Mike Chaney and Andy Case (MS); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Tracy Biehn (NC); Bruce R. Range and Martin Swanson (NE); Chris Nicolopoulos represented by David Bettencourt and Christian Citarella (NH); Marlene Caride represented by Randall Currier (NJ); Russel Toal, Leatrice Geckler and Anna Krylova (NM); Barbara D. Richardson and Gennady Stolyarov (NV); Judith L. French represented by Lori Barron (OH); Glen Mulready (OK); Andrew R. Stolfi and TK Keen (OR); Jessica K. Altman, Michael Humphreys and Michael McKenney (PA); Raymond G. Farmer and Michael Wise (SC); Larry D. Deiter and Maggie Dell (SD); Carter Lawrence represented by David Combs, Bill Huddleston and Patrick Merkel (TN); Doug Slape (TX); Jonathan T. Pike (UT); Scott A. White, Vicki Ayers and Rebecca Nichols (VA); Michael S. Pieciak represented by Rosemary Raszka (VT); Mike Kreidler represented by Molly Nollette (WA); Mark Afable, Nathan Houdek and Timothy Cornelius (WI); and James A. Dodrill and Joylynn Fix (WV).

1. Adopted its 2020 Fall National Meeting Minutes

Superintendent Toal made a motion, seconded by Ms. Biehn, to adopt the Task Force’s Dec. 4, 2020, minutes (see NAIC Proceedings – Fall 2020, Innovation and Technology (EX) Task Force). The motion passed unanimously.

2. Adopted its Working Group Reports

a. Big Data and Artificial Intelligence (EX) Working Group

Commissioner Ommen gave the report of the Big Data and Artificial Intelligence (EX) Working Group. He said it held its first meeting March 29. During this meeting, the Working Group: 1) reviewed the key accomplishments of the Big Data (EX) Working Group and the Artificial Intelligence (EX) Working Group; 2) noted the merging of these working groups into the new Big Data and Artificial Intelligence (EX) Working Group; 3) reviewed its 2021 charges; and 4) focused on its charge to research where the industry is applying the use of big data, algorithms and artificial intelligence (AI), while simultaneously studying model governance structures.

Commissioner Ommen said the Working Group had a more in-depth discussion about developing an industry survey to research how insurance companies are using big data, algorithms and AI, while protecting the confidentiality of individual company practices. He said the Working Group agreed to limit the scope and the initial research, with the likely focus being on private passenger automobile insurance, and it directed a small group of subject matter experts (SMEs) to coordinate with NAIC staff to draft an industry survey for further review by the Working Group. He said Superintendent Dwyer and Commissioner Afable will lead that effort with SMEs from Connecticut, Illinois, Louisiana, Nevada, North Dakota, Pennsylvania, Rhode Island and Wisconsin.

Commissioner Ommen said the Working Group also heard a presentation introducing the components of a model governance framework based on other models, such as capital and catastrophe models, and how to minimize risks arising from models. He said the presentation explained the benefits of model governance and the key components, including oversight, controls and validation.
b. Speed to Market (EX) Working Group

Ms. Nichols gave the report from the Speed to Market (EX) Working Group. She said the Working Group met March 10 and discussed the results of the Product Requirements Locator (PRL) survey and next steps. She said this topic was part of a bigger study to determine what speed to market tools state insurance regulators find most useful. She said the results indicated that states fall into three categories. She said the first is a group of states who will have their PRL information removed as they are not using it and have no intention to going forward. She said the second group are states that are using the tool, and their support of it will continue until integration to System for Electronic Rate and Form Filing (SERFF) modernization is complete. She said the third group are undecided states, and the SERFF team will be reaching out to states based on the survey responses provided to gather additional information, as needed, to assist states using the PRL. She said it is unlikely that the PRL tool will be available beyond the completion of the SERFF modernization project, as the SERFF modernization project anticipates including ways for states to provide their filing requirements within SERFF, making it easier for states to keep their requirements up to date and satisfy the need for those requirements to be easily accessible to SERFF users.

Ms. Nichols said the Working Group received updates on SERFF, including recent and upcoming releases and projects and an update on the Interstate Insurance Product Regulation Commission (Compact). She said the Working Group discussed the annual review of the product coding matrix (PCM) and uniform transmittal document (UTD) suggestions, and proposed revisions or changes can be submitted at any time throughout the year. However, for suggestions to be considered to go in effect for next year, the deadline is May 31. Ms. Nichols said an alert will be sent out to remind users of that deadline, and a meeting set up to discuss those submissions will be arranged.

Commissioner Godfread asked if there were any questions regarding any of the Working Group reports. Hearing none, Commissioner Clark made a motion, seconded by Ms. Biehn, to adopt the following reports: 1) Big Data and Artificial Intelligence (EX) Working Group, including its March 29 minutes (Attachment One); and 2) Speed to Market (EX) Working Group, including its March 10 minutes (Attachment Two). The motion passed unanimously.

3. Received an Update on the Innovation and Technology State Contacts Activity

Denise Matthews (NAIC) provided a report from the Innovation and Technology State Contacts Roundtable meeting that was held April 1. She said the roundtable is led by Mr. Aufenthie and Mr. Bradner. She said 43 state insurance regulators from 35 states participated in the roundtable. During the meeting, the co-leaders solicited interest regarding helping to lead the group. Ms. Matthews said the agenda included a discussion on strategies for improving state insurance regulators’ access to data from an insurer’s perspective and a discussion related to parametric products led by a presentation from Commissioner Hayashida. She said other topics were on the agenda, but these two generated a lot of discussion, so they will be put on a future agenda. She said guests from Travelers and Hartford presented on the open Insurance Data Link (openIDL) solution and discussed the benefits and challenges associated with getting more carriers to participate. She said the presenters talked about the pandemic having slowed the process to gain more participation. She said Commissioner Hayashida gave a presentation on parametric insurance products, discussing the pros and cons and where it can be helpful in filling insurance coverage gaps. She said the state insurance regulators suggested that there may be a need to draft principles and standards or guidelines around these types of products, particularly in the area of transparency and the provision of clear information to consumers.

4. Discussed RFIs Related to Continuing Specific “Regulatory Relief” or “Regulatory Accommodations” Offered by States Related to the COVID-19 Pandemic

Commissioner Godfread reminded the members of the Task Force that a Request for Information (RFI) was sent to interested parties in 2020, asking for information related to specific “regulatory relief” or “regulatory accommodations” offered by states as a result of the COVID-19 pandemic, that they would recommend be continued or made permanent, related to innovation and technology. He said the RFI asked whether there was some type of regulatory relief or accommodation offered or if there continues to be a law, regulation, regulatory guidance or established practice in place that prohibits or limits insurers or producers from implementing or using newer technologies, data, methods or processes that is now necessary in order to continue to serve customers and maintain operations. He said the responses to that RFI were compiled into a summary presented during the 2020 Fall National Meeting, and they were grouped into four categories, including which organizations offered a similar or the same suggestion. He said those categories were:

- Electronic Commerce
- Regulatory Capabilities
- Claims Facilitation
- Items Specific to Surplus Lines

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Commissioner Godfread said while most of the responses did not include the specific statutes or statutory language the American Council of Life Insurers (ACLI) recommended eliminating or revising, it did send a specific recommendation suggesting developing a bulletin or bulletins to address concerns related to existing issues with the state-by-state implementation of e-signature laws, including the Uniform Electronic Transactions Act (UETA) and existing obstacles to moving e-commerce forward. He said it was decided that more information is needed to move into specific actions, so another RFI was sent to the respondents of that initial RFI and a consumer representative, asking them to provide more specific information as to where the issues are more interpretative or lack a uniform interpretation, versus it being a legislative issue. He said the intention was to identify which should be a priority to address in 2021. He said a summary compilation of those responses (Attachment Three) are in the materials, showing that respondents prioritized e-commerce, including allowing for e-signatures, e-delivery of documentation and information, e-notary, and changing the paradigm from what is mostly an “opt-in” scenario today to an “opt-out,” where getting and exchanging information electronically or digitally would be the default, with consumers having the ability to “opt-out” of that option. He said the ACLI and the American Property Casualty Insurance Association (APCIA) suggested forming a working group to survey states about UETA exceptions to begin work on any laws and regulations that need to be changed to accommodate this and work on interpretive guidance where legislation changes are not needed.

Commissioner Godfread said the second category represents regulatory capabilities and covers a list of items related to allowing online continuing education (CE) and training, allowing electronic filings for regulatory filings, and eliminating wet signature requirements. He said there were no specific action suggestions for this category, but deferring the education and training item to the Producer Licensing (D) Task Force may be appropriate. He said claims facilitation was a category of responses from the first RFI, but it did not appear to “make the cut” when this second group of respondents was prioritizing. He said the last category is specific to surplus lines, and a couple of the respondents noted that the Surplus Lines (C) Task Force is currently working to amend the Nonadmitted Insurance Model Act (#870), and it may be appropriate to defer this to it as a part of that work. He said an interested party noted that some of the areas to address include home state taxation, insurer eligibility, exempt commercial purchaser, and diligent search.

Commissioner Godfread said three respondents—the ACLI, the APCIA, and the Professional Insurance Agents (PIA)—indicated support for the drafting of a model bulletin to cover some of the non-legislative issues. He said while not included in the summary document, a letter from the Center of Economic Justice (CEJ) was received. He said the letter notes the successes in terms of the response to the pandemic to continue services to consumers, but it also notes a few problems around a lack of tools to oversee and monitor these sudden changes and digital interactions. He said it covers the issues related to risk exposure changes, such as in personal auto insurance and the impact of credit-based insurance scores, and a lack of regulatory data collection should be noted. A lack of clear guidance related to consumer-generated data and ownership and consent to use issues needs to be considered.

5. Discussed an Approach to Drafting a Guidance Document/Bulletin

Commissioner Godfread said he heard several options for how to move forward with addressing these issues. He said he would be comfortable with a motion to look at creating a working group that would examine the issues identified; working on a bulletin; and referring specific issues, as appropriate, to the Producer Licensing (D) Task Force and the Surplus Lines (D) Task Force. Superintendent Dwyer made a motion, seconded by Commissioner Birrane, to form such a group. In response to a question in the chat, Commissioner Godfread said the group would be open to feedback, and regarding this topic, the Innovation and Technology (EX) Task Force has been very responsive to the stakeholders and would continue to be. He said whether it is a drafting, working or best practices group, that engagement will continue to be encouraged. The motion passed unanimously. Commissioner Godfread encouraged anyone interested in participating in the process to notify Ms. Matthews so it can get moving forward.

6. Heard InsurTech Presentations

a. State Farm/USAA Auto Subrogation Blockchain Solution

Commissioner Godfread introduced the first presenters from State Farm and the United States Automobile Association (USAA), saying these two legacy carriers and competitors have joined forces to create something using blockchain technology that makes sense for consumers. It demonstrates how it can make them more efficient and minimize cost through the development of a subrogation blockchain solution. He said Beth Carter, the Director of P&C Claims Business Technology at State Farm, and Luke Harris, Assistant Vice President and Senior Experience Owner in USAA’s Claims Organization, will present on this topic.
Ms. Carter said State Farm recognizes that the partnership with USAA on this blockchain solution is important to innovate and build for the future. She provided the background and history behind the project, and she said after extensive testing, it is now in full production and serving to settle claims between the companies using blockchain, representing the first of its kind. Mr. Harris said it provides data security and data control, as well as oversight and validation also leveraging Distributed Ledger Technology (DLT) to offer a secure and immutable record of transactions that can be validated and confirmed through consensus. He said there is no need to transmit Personally Identifiable Information (PII), and it removes a lot of cost from the process. Ms. Carter said it also makes processes more efficient and secure; eliminates manual steps, allowing them to get the deductible back to the consumer faster, reducing external disruptions with processing single check recoveries; and minimizes the amount of subrogation funds floating through the industry. Mr. Harris said State Farm and USAA have created something that can be adopted by the entire industry, and they are on a quest to bring in additional carriers to this platform, as the more that participate, the greater the benefit.

Commissioner Godfread said North Dakota is working on blockchain solutions, and he asked if there is anything state insurance regulators can do to encourage more companies to get involved. Mr. Harris said discussions like this are helpful, and providing forums to help and educate regarding this solution is beneficial.

b. Trellis Connect

Commissioner Godfread said Daniel Demetri, the Founder and Chief Executive Officer (CEO) of Trellis, will talk about what Trellis is, what it does, and the issue of consumer data ownership. Mr. Demetri said Trellis is a technology company in San Francisco operating nationally out of Arizona, Florida, Indiana, New York and Tennessee, offering in all 50 states and Washington, DC. He said it helps consumers navigate insurance as they move online using apps to allow their information to be shared with the advisor app they have selected. He said consumers need personalized insurance experiences online and digital experiences in the way they work with agents. He said Trellis provides consumers the ability to rely on and share data, allowing them to share their insurance information for many different purposes. He said it does not require any changes to producer licensing, and Trellis only allows licensed producers to get access to the information. He said state insurance regulators should determine what the parameters around this should be and what rights consumers should have to their insurance data in terms of who owns it and how they can access it. He said many insurers elect to block consumer access for security or competitive purposes, and he urged state insurance regulators to consider what the data access rights are in each state and how they translate to the online environment.

Commissioner Godfread said North Dakota took a run at this during the current legislative session, but it was unsuccessful. He said even so, this is interesting, important, and likely something the Innovation and Technology (EX) Task Force will need to consider.

c. Vero

Commissioner Godfread introduced the next presenter, Ali Safavi, Co-Founder and CEO of Vero. Mr. Safavi said the future of guidance and advice is exciting, and making insurance cheaper, faster, quicker, and with more focus on guiding and bringing the advice piece online is the goal of Vero. He said consumers need protection and guidance; risk is changing, and insurance products have traditionally been built around risks as opposed to people. He said Vero is investing in an AI risk and insurance advisor that would be unbiased with no incentive in terms of how the recommendation is given. He said it is holistic and automates making it easier to integrate online. He said it augments the agent channel, making products more affordable with better service and better risk management through risk mitigation. He said Vero is starting with the digitalization of the existing agent channel, but over time, it will likely move to full integration of agent and direct channels and then move to the consumer starting online with some human components. He demonstrated how the Vero product assists with this by providing a risk report and a recommendation based on a calculated protection score. He said the biggest challenge to being able to do this is not being able to get access to the consumer’s information, as mentioned during Mr. Demetri’s presentation. He said there are two big implications: 1) currently, state insurance regulators look at licensing as a way to protect consumers, ensuring that agents know what they are doing and know and understand the regulations; but Vero believes that if AI can provide guidance, present quotes, and do a better job than the agent—i.e., the agent is just doing marketing—the question would be if the licensing requirements need to be the same for that as for a traditional agent; and 2) while regulations can be a barrier, actually enforcing insurers through regulation to give better access to consumer data could boost innovation as opposed to being a barrier.

Ms. Jabourian asked how many and what the demographics were regarding the survey quoted. Mr. Safavi said it was in the thousands, but he would be happy to provide the actual report. Ms. Jabourian asked if Vero is licensed as a financial advisor, managing general agent (MGA), or something else in order to provide financial advice. Mr. Safavi said Vero is not providing financial advice at this time, but it does have both individual and company producer licenses. Ms. Jabourian asked what
information Vero is gathering to assess what additional coverage is needed and how much information a consumer must divulge to get a recommendation. Mr. Safavi said most agents do not have this type of data. He said the biggest factor is net worth, and Vero uses an actuarial model to determine risk, using data that agents do not have.

In responding to questions in the chat, Mr. Safavi said Vero has life, health and property/casualty (P/C) producer licenses, and while currently working on personal lines, small commercial will be next. He said Vero is proud of its Errors & Omissions risk product because that area has a lot of human error, and by automating it, it is much improved.

7. Heard Updates from Committees and Working Groups

Commissioner Godfread asked representatives from other committees whose charges involve related workstreams to those the Innovation and Technology (EX) Task Force is addressing to provide updates.

a. Special (EX) Committee on Race and Insurance

Commissioner Mais said five workstreams have been set up and are working under the Special (EX) Committee on Race and Insurance to look at issues concerning race and insurance. He said the first two workstreams deal with diversity in the industry and the regulatory community, and the other three workstreams deal with issues of unfair treatment as it relates to the three major lines of business; i.e., life, health and P/C. He said each of the workstreams issued a draft report to the Special Committee, and the Special Committee has exposed a summary report that will be discussed during its April 12 meeting. He said generally, the exposed report currently calls for continued research and analysis of insurance legal and regulatory approaches to addressing unfair discrimination, specifically proxy discrimination and disparate impact, by defining the terms and determining appropriate steps to address, including: 1) the impact of traditional life insurance underwriting on minority populations; 2) considering the relationship between mortality risk and disparate impact; and 3) developing analytical and regulatory tools to assist state insurance regulators in determining unfair discrimination. He said the report also calls for enhanced data reporting and record-keeping requirements across product lines to identify race and other socio-demographic factors of insureds, and a data call may be considered to identify resources and products sold in specific zip codes to identify barriers to access. He said finally, the report calls for coordinating with existing groups, specifically the Big Data and Artificial Intelligence (EX) Working Group and the Casualty Actuarial and Statistical (C) Task Force, and encouraging the Casualty Actuarial and Statistical (C) Task Force to continue its work in predictive modeling, price algorithms and AI, with a particular focus on how race is affected.

b. Accelerated Underwriting (A) Working Group

Commissioner Afable said the Accelerated Underwriting (A) Working Group last met March 19 in lieu of meeting at the Spring National Meeting. He said a drafting group made up of several state insurance regulators and led by Commissioner Arnold is coming up with a first draft of the Working Group’s work product, and the Working Group has agreed to develop an educational report, the primary purpose of which is to offer guidance to state insurance regulators, industry, consumer advocates, and other stakeholders. He said the report will be narrowly focused on accelerated underwriting in life insurance and consider the work of other NAIC groups like the Innovation and Technology (EX) Task Force, the Big Data and Artificial Intelligence (EX) Working Group, the Casualty Actuarial and Statistical (C) Task Force, and the Privacy Protections (D) Working Group, and a draft outline of the report has been circulated. The outline includes three major issues as they relate to accelerated underwriting in life insurance: 1) input data; 2) algorithms and machine learning; and 3) transparency and privacy.

c. Property and Casualty Insurance (C) Committee

Commissioner Schmidt said the Property and Casualty Insurance (C) Committee will be involved with issues related to the Special (EX) Committee on Race and Insurance. She said it appears that the charges being discussed will stay with the Special Committee and not be referred to the Property and Casualty Insurance (C) Committee. She said there is a charge to look at the development of analytical and state insurance regulator tools to assist in determining unfair discrimination, specifically the use of socio-economic variables and identifying proxy variables for race; correlation versus causation; disparate impact considerations; the use of third parties; and the appropriate use of certain data, such as criminal history information. She said to expect that the first step after new charges are adopted will be convening chairs and vice chairs of the various committees to come up with a workplan, identifying the right people to work on them and ensuring that there is no duplication of work as relevant terms and processes are defined.
d. Privacy Protections (D) Working Group

Ms. Amann said the Privacy Protections (D) Working Group is looking at the overlap between cybersecurity and data protection. She said they are interrelated but two completely different issues. Other major issues continuing to develop is the ownership of data. Ms. Aman said concerns about data privacy protections, as well as ownership and opting in and opting out, continue to be topics the Working Group is looking at. She said the Working Group received a report from NAIC staff on federal and state privacy legislation. She said the federal report indicated that the U.S. Congress (Congress) believes there is a need for federal data privacy legislation, but differences in approaches have thwarted efforts to enact comprehensive legislation thus far. The key points of contention include: 1) whether, and to what extent, federal legislation should preempt state laws; and 2) whether the legislation should include a private right of action. Ms. Amann said the NAIC continues to engage with Congress, oppose preemptive legislative proposals, and inform Congress of the Working Group’s efforts to update NAIC models. She said the NAIC continues to underscore the importance of not disregarding the existing state regulatory framework or inhibiting ongoing efforts in the states to develop laws and regulations in the best interest of insurance consumers.

Ms. Amann said the state report indicated that at least 30 states have introduced some form of data privacy legislation in 2020. Most of them were comprehensive and similar to the California Consumer Privacy Act (CCPA), but very few of them were enacted due to the COVID-19 disruption of legislative sessions. Ms. Aman said the Working Group continues to monitor this area. She said privacy bills have been introduced in 23 states that focus on business obligations stemming from consumer rights, but they vary in substance. Many of these bills apply to for-profit businesses, but all are over the board. She said no template has emerged yet, but some common issues have, such as: 1) a requirement that covered entities perform a risk assessment; 2) providing a private right of action; 3) addressing data security and data privacy; 4) resembling the General Data Protection Regulation (GDPR); and 5) exempting data collected in compliance with the Gramm-Leach-Bliley Act (GLBA), as well as entities subject to the GLBA.

Ms. Amann said the Working Group discussed comments received after the Working Group’s Nov. 20, 2020, meeting in lieu of the 2020 Fall National Meeting. She said there was a verbal gap analysis from the ACLI, the Coalition of Health Carriers, the National Association of Mutual Insurance Companies (NAMIC), and the APCIA. She said the Working Group announced the consumer privacy protections panel scheduled for the virtual NAIC Insurance Summit in June. She noted that this is an ever-changing topic for the Working Group as the development of the cyber and data ownership issues have shown, and the Working Group will be reaching out to coordinate with other committees on these topics.

8. Discussed Other Matters

Commissioner Godfread said the two agenda items the Innovation and Technology (EX) Task Force was unable to cover today, the discussion on consumer data ownership issues and potential guidance and the NAIC report on the Predictive Model Review Process, will be included in the agenda for the next meeting of the Task Force. He said the “Coded Bias” event hosted by the NAIC was an outstanding event, and he said it is an important film to see. He said 900 registered for the event, and 550 tuned in for the panel. He said it was a great panel session, and there was so much interest that there will be a follow-up of some kind to cover all the outstanding questions submitted. He said exactly what that will be has not yet been determined, but he said to stay tuned and any suggestions should be sent to himself or Ms. Matthews.

Having no further business, the Innovation and Technology (EX) Task Force adjourned.
Big Data and Artificial Intelligence (EX) Working Group
Virtual Meeting (in lieu of meeting at the 2021 Spring National Meeting)
March 29, 2021

The Big Data and Artificial Intelligence (EX) Working Group met March 29, 2021. The following Working Group members participated: Doug Ommen, Chair, and Travis Grassel (IA); Elizabeth Keller Dwyer, Co-Vice Chair (RI); Mark Afable, Co-Vice Chair (WI); Katie Hegland (AK); Daniel Davis (AL); Ken Allen (CA); Peg Brown (CO); Andrew N. Mais, George Bradner and Wanchin Chou (CT); Frank Pyle (DE); Rebecca Smid (FL); Judy Mottar (IL); Satish Akula (KY); Tom Travis (LA); Kathleen A. Birrane (MD); Benjamin Yardley (ME); Matthew Vatter and Phil Vigliaturo (MN); Cynthia Amann (MO); Kathy Shortt (NC); Chris Aufenthie (ND); Christian Citarella (NH); Barbara D. Richardson and Gennady Stolyarov (NV); Lori Barron (OH); Eli Snowbarger (OK); Shannen Logue and Mike McKenney (PA); Michael Wise (SC); David Combs (TN); J’ne Byckovski and Rachel Cloyd (TX); Kathy Stajduhar (UT); Eric Lowe (VA); Christina Rouleau (VT); and Eric Slavich and John Haworth (WA).


Commissioner Ommen said the Big Data (EX) Working Group and the Artificial Intelligence (EX) Working Group have been merged to form the Big Data and Artificial Intelligence (EX) Working Group. He provided an overview of the prior work of the Big Data (EX) Working Group and the Artificial Intelligence (EX) Working Group.

In 2018, Commissioner Ommen said the Big Data (EX) Working Group received a presentation from LIMRA on the use of data for the underwriting of life insurance products, and it was followed by the efforts of the Casualty Actuarial and Statistical (C) Task Force, which was developing guidance on best practices for the review of predictive models. He said the Big Data (EX) Working Group focused discussions on accelerated underwriting led to the appointment of an Accelerated Underwriting (A) Working Group. He said the NAIC moved forward with training in 2019, as recommended and encouraged by the Big Data (EX) Working Group. This training focused on rate filings using complex algorithms, and it included technical training for actuaries and non-technical training for rate filing reviewers. Commissioner Ommen said the Big Data (EX) Working Group discussed the use of data in fraud detection and claim settlements, which included two presentations from the Insurance Services Office (ISO) and a presentation from the National Insurance Crime Bureau (NICB). He said the Working Group discussed whether state insurance regulators have the appropriate regulatory authority under existing unfair trade laws and unfair claims settlement regulations to address marketplace practices. He said the NAIC, at the urging of the Big Data (EX) Working Group, implemented technical services in 2020 to assist state insurance regulators in the review of property/casualty (P/C) rate models.

Commissioner Ommen said the Artificial Intelligence (EX) Working Group was appointed in 2019, and it developed and approved Artificial Intelligence (AI) Principles for the insurance industry. The NAIC’s AI Principles outline five key tenets for AI actors, summarized with the acronym FACTS: Fair and ethical, Accountability, Compliance with existing laws, Transparency for consumers, and Safe and secure data systems. Commissioner Ommen said another important work product came from the Innovation and Technology (EX) Task Force, which adopted revisions to the NAIC’s Unfair Trade Practices Act (#880). These revisions clarify that value-add products and services using new technology are not considered rebates if the service or value-add product relates to risk being underwritten and primarily designed to provide loss mitigation or loss control or reduce claim settlement costs.

Commissioner Ommen said the charges of the new Big Data and Artificial Intelligence (EX) Working Group will require the Working Group to adopt a problem-solving approach. The Working Group will need to take a deeper dive with more granular-level research of where the industry is applying the use of big data, algorithms, and AI. Commissioner Ommen said this work will be completed while simultaneously studying governance structures that could be considered as best practices and guidance to state insurance regulators seeking to understand how the industry should be managing risks associated with the use of big data and AI. He said the charges that will require the Working Group to develop and prioritize solutions and set deliverables, while recognizing an intermediate deliverable, will not necessarily finish the Working Group’s charge.
2. **Discussed an Approach to Developing an Industry Survey for Research**

Commissioner Ommen said NAIC members have heard over the past two years public presentations on the use of big data and innovation. At the same time, he said he would receive requests from state insurance regulators to hear more about insurers’ electronic data variables, algorithms, and use of AI. Because of this, he said he would like to get a more accurate and objective measure of what is happening. He said individual insurers have expressed a desire to share information, but there is reluctance to do so without assurances around protecting trade secrets and intellectual property.

Superintendent Dwyer suggested that the Working Group conduct an anonymized survey in a specific line of insurance with one lead state that can provide confidentiality protections. She said the Working Group is not trying to scrutinize any individual company’s practices, but it is trying to understand broader market practices. Commissioner Afable said insurers are at different stages of using algorithms and models, and state insurance regulators need to understand how insurers are leveraging this technology. He agreed with the need to focus on a specific line of insurance, and he suggested that a small group of state insurance regulator subject matter experts (SMEs) work with NAIC staff to create an initial draft of a survey.

Mr. Vigliaturo said the survey should address insurers’ use of third-party vendors and the use of models supplied by these vendors. Mr. Grassel suggested focusing on commercial and personal auto due to the large amount of data being collected for these lines of insurance. In response to Mr. Haworth’s questions about the use of market conduct exam authority to collect information, Superintendent Dwyer said the Working Group would use this authority for the confidential collection of information, but it would not use this authority for market conduct enforcement or the issuance of a public market conduct report of a specific company. Mr. McKenney agreed with starting with commercial and personal auto, and he suggested looking into the use of telematics. Mr. Bradner suggested that the survey include the review of how data and algorithms are used for claims. Mr. Chou suggested that life and health underwriting might be a good line area of focus.

Mr. Vatter said the Working Group should coordinate with the Special (EX) Committee on Race and Insurance. Superintendent Dwyer said the Working Group will also coordinate with the Property and Casualty Insurance (C) Committee if the survey focused on automobile insurance. Commissioner Ommen said other groups may be informed by our research, and that is why the Working Group needs to narrow its focus and move quickly. Commissioner Afable said the Working Group would also coordinate with the Accelerated Underwriting (A) Working Group if more research is needed for life insurance.

Birny Birnbaum (Center for Economic Justice—CEJ) suggested that the Working Group focus on one line for P/C insurance and life insurance. He said the survey tool could be used for both lines of insurance, and a survey of life insurance would help inform the Accelerated Underwriting (A) Working Group. He said the survey should ask for data used, the source of data, algorithms used, and the application of use. He said the identification of third-party vendors is important. He said the survey should help identify what percentage of the marketplace is using a specific data element for a specific application, such as criminal history information.

John Lucker (Universal Fire and Casualty Insurance Company) said the survey should focus on models, algorithms and data sources. Mr. Lucker said the output of the models and algorithms is dependent on data, and the identification of third parties should include both data vendors and developers of algorithms.

Angela Gleason (American Property and Casualty Insurance Association—APCIA) said the APCIA would like to work with state insurance regulators, and confidentiality is very important. She said some insurers may not provide information from vendors because of confidentiality agreements with vendors.

Superintendent Dwyer suggested that a small group of state insurance regulator SMEs begin working on the survey for further review by the Working Group. Commissioner Ommen, Superintendent Dwyer and Commissioner Afable will lead this effort, and Commissioner Ommen suggested some state insurance regulators who are members of the Casualty Actuarial and Statistical (C) Task Force.
3. Heard a Presentation on a Model Governance Framework

In support of starting the Big Data and Artificial Intelligence (EX) Working Group’s discussions on model governance for the use of big data and AI, Commissioner Ommen said Elisabetta Russo (NAIC), the NAIC’s ERM Advisor and expert on model governance, will provide an overview of the components of a model governance framework.

Ms. Russo said the introduction of the Own Risk and Solvency Assessment (ORSA) requirements in 2012 for insurers and the expansion of the risk-based capital (RBC) formula to include catastrophe risks have brought capital models and catastrophe models onto the radar of state insurance regulators. She said these models are widely used to make important business decisions by insurers, and state insurance regulators have had to answer questions such as how the models are used, what risks are associated with the use of the models, whether state insurance regulators should examine the models, and if so, how this review should occur. She said the NAIC has been working with state insurance regulators, industry, and vendors in a collaborative manner for the past two years on answering these questions. Ms. Russo said state insurance regulators have engaged with industry and vendors to understand the models, developed review procedures for state insurance regulators, tested these procedures by conducting model walk-throughs with industry and vendors on a voluntary basis, and trained state insurance regulators. She said the next step is to enhance the regulatory requirements, such as the \textit{NAIC ORSA Guidance Manual}; operationalize the review procedures by incorporating them into the NAIC’s financial analysis and financial examination handbooks; develop tools for state insurance regulators; and consider not just solvency implications, but also rating review implications.

Ms. Russo said insurers that use capital models and catastrophe models have developed model governance frameworks to help their use of these models. She said this includes minimizing risks arising from models, supporting the business use of model outputs, providing assurance on model outputs to boards of directors, and providing assurance on output and use to the state insurance regulators. She said the models need to run for some time before a robust model governance framework can be in place. Ms. Russo said AI models are new compared to other models. She said it is important to start with the anatomy of the model. There is an input, calculation engine and output. Ms. Russo said there are also business drivers and key risks, and state insurance regulators should start by reviewing these steps and risks to understand how a model works. She said state insurance regulators need to understand the key risks, which include the model risk, data risk, third-party risk, technology risk, compliance risk, and business process risk. She said state insurance regulators can then determine the appropriate oversight once the risks are understood.

Ms. Russo suggested starting with model oversight and controls and leaving validation for later when models are more mature and documented. She also suggested developing baseline requirements for the following model components: the input, the calculation engine and output. She suggested organizing the set or principles, such as the AI Principles adopted in August 2020, under baseline requirements for each component. She said the Working Group should leverage existing model governance practices and then tailor a model governance framework for big data and AI models to reflect the risks that are unique.

Mr. Birnbaum said there is a difference between financial models for prudential supervision and consumer-facing models. He said consumer-facing models should be tested against marketplace outcomes, and suggested model governance may not lead to desired consumer outcomes. He said while financial models are required by state insurance regulators, consumer-facing models are used for a variety of reasons and at the discretion of insurers. He said financial model governance has practices that can be transferred to consumer-facing models, but model governance will be different for consumer-facing models.

Having no further business, the Big Data and Artificial Intelligence (EX) Working Group adjourned.
The Speed to Market (EX) Working Group of the Innovation and Technology (EX) Task Force met March 10, 2021. The following Working Group members participated: Rebecca Nichols, Chair (VA); Maureen Motter, Vice Chair (OH); Katie Hegland (AK); Jimmy Gunn (AL); Jimmy Harris (AR); Frank Pyle (DE); Heather Droge (KS); Jo LeDuc (MO); Tammy Lohmann (MN); Garlinda Taylor (NC); Chris Aufenthie (ND); Jimmy Harris (AR); Frank Pyle (DE); Heather Droge (KS); Jo LeDuc (MO); Tammy Lohmann (MN); Garlinda Taylor (NC); Chris Aufenthie (ND); Russell Toal (NM); Cuc Nguyen (OK); Mark Worman (TX); Tanji J. Northrup (UT); Lichiou Lee (WA); and Barry Haney (WI).

1. **Adopted its Nov. 10, 2020, Minutes**

The Working Group met Nov. 10, 2020, and took the following action: 1) adopted its Sept. 29, 2020, minutes; 2) discussed the Product Requirement Locator (PRL) tool; and 3) discussed communications plans for speed to market tools.

Ms. Droge made a motion, seconded by Mr. Toal, to adopt the Working Group’s Nov. 10, 2020, minutes (see NAIC Proceedings – Fall 2020, Innovation and Technology (EX) Task Force, Attachment Two). The motion passed unanimously.

2. **Received an Update from the Compact**

Susan Ezalarab (Interstate Insurance Product Regulation Commission—Compact) stated the full Compact plans to meet on March 23 to consider amendments to five uniform standards to change the definition of the “non-forfeiture rate” to follow state law, which relates to the recent model adoption by the NAIC. The Compact will also be considering amended standards for waiver of premium, waiver of monthly deductions and a new standard for waiver of surrender charges when the insured under a life insurance policy meets certain benefit triggers. She noted the Compact also established a governance committee to review recommendations resulting from a governance review and some business assessment reports. In addition, the committee will review questions raised by a Colorado Supreme Court case to determine if there needs to be changes to the Compact structure and processes that would provide more flexibility for states to deal with any conflicts between their state laws and the uniform standards of the Compact. The most active committee is the Product Standards Committee (PSC), and it is working on amendments to the minimum non-forfeiture law uniform standards. The PSC is also considering a request from South Carolina to amend the long-term care (LTC) uniform standards for rate review. She noted the PSC is also reviewing comments on group term life insurance standards as part of the five-year review process and that all uniform standards are reviewed every five years if updates are needed.

Ms. Ezalarab noted that meeting summaries are posted to the Compact website and that all state insurance regulator members can attend and participate in any of the committee meetings. She stated another active committee is the Rule Making Committee, which has held two public meetings to gather information about how states approve non-employer group types. The group standards in the Compact right now only apply to employer groups, and there has been a request to expand that to non-employer groups, such as associations and similar groups. The Committee will decide whether to recommend expanding the uniform standards to accommodate for non-employer groups.

3. **Discussed the Results of the PRL Survey and Next Steps**

Ms. Nichols stated earlier discussions regarding the PRL tool last year resulted in a survey being generated to get feedback from the states that have previously populated the PRL. The portable document format (PDF) version of these results was emailed with the meeting invitation and is also posted to the Speed to Market (EX) Working Group web page. She noted the responses showed that while several states still find the PRL to be a valuable tool for their state, most states are not using the tool. Based on the survey feedback, the states’ responses fall into one of three categories regarding the PRL right now: 1) the states that will have the PRL information removed since they are not using it and do not plan to; 2) the states that are using it and their support for the PRL tool will continue until integration to the System for Electronic Rate and Form Filing (SERFF) modernization is complete; and 3) the states that are undecided. She stated the SERFF team will be reaching out to the undecided states to assist them in determining the best way to proceed until the SERFF modernization project is complete. The SERFF team will also be working with any states that are currently using the PRL to make sure the assistance they need in transitioning from using it is provided.
Ms. Nichols stated that as SERFF continues to evolve, some of the speed to market tools will also evolve. With that in mind, even if the Working Group takes no action to discontinue the PRL at this time, it is unlikely that the PRL will be a permanent tool and equally unlikely that it will be available beyond the completion of the SERFF modernization project. She noted it is more likely that the SERFF modernization project will include ways for states to provide their filing requirements in SERFF, making it easier for states to keep their requirements up to date and to satisfy the need for the requirements to be easily accessible to SERFF users. The timeline for transitioning out of PRL use and into SERFF use is still unknown, but it looks like for the states still using the PRL, it is a couple of years down the road. Ms. Nichols reiterated that assistance will be provided to those states when the time comes to make the transition.

Mr. Toal stated that as a member of the SERFF team, he agrees with what has been stated on this topic and that he thinks the timeline for the new SERFF capabilities is a year and a half or so. Ms. Motter stated that in the interim, between now and when the SERFF modernization project is complete, by cleaning out the obsolete or incorrect information currently in the PRL for some states, it will make it a better tool for the industry to use for the states that do have current information in the PRL.

4. Received an Update on SERFF

Brandy Woltkamp (NAIC) stated the SERFF development team has been busy working on recent updates. Release number 7.54 was put into production on Nov. 5, 2021. This release completed the third phase of the billing project, and the updates included the ability for the NAIC transaction fees to be paid upon on submission with a new payment method of credit card if the instance is enabled for those credit card payments. The release also included a label change for all life, accident and health (A&H), annuity and credit filings from implementation date to effective date, which was at the direction of this Working Group.

Ms. Woltkamp stated the next release was 7.55, which went into production on Jan. 21, 2021. This release completed the final phase of the billing redesign work, which is moving all customers to pay NAIC transaction fees at submission with automated clearing house (ACH) debit, electronic funds transfer (EFT) or credit card, along with the previous release. The 7.55 release will go into place for any instance that does not have existing filing block units; if a filing block unit is in place, they would not be transitioned to paying at submission until the units have been fully used or they expire, at which time the instance will automatically be transitioned over to EFT or credit card. She noted two other enhancements and fixes included in the 7.55 release: 1) a hyperlink for the SERFF tracking number on the Form Schedule and the Rate/Rule schedule; and 2) hyperlinking was added to the form number on the Form Schedule. Those enhancements were completed on property/casualty (P/C) filings only because those enhancements were already completed on life, A&H, annuity, and credit filings.

Ms. Woltkamp stated the latest release is SERFF 7.56, which was released March 4, 2021. The first component revised the industry to an application programming interface (API) service. She encouraged anyone interested in the API service to reach out to the SERFF team. Additional updates in this release included the new state report, which was also at the direction of this Working Group; the State Rate Data report is available to all state users on the reports tab. Ms. Woltkamp noted another enhancement included is the ability for each user to set his or her own landing page upon initial log in, or the landing page when switching instances; an alert was sent out regarding the release that provided information on how to do that.

Ms. Woltkamp noted an upcoming project for this year is the Plan Management Project. This project involves working with the federal Centers for Medicare & Medicaid Services (CMS) to consolidate processes to make things easier for issuers, states and NAIC support staff. It will consist of two pieces: 1) federal reporting for state-based marketplaces (SBMs); and 2) the transfer of specific documents contained on rate filings. The first piece of work is on the specific pieces of information for SBMs that are submitted in the financial management (FM) data report and public use file (PUF) processes; these are processes where data was collected in the back end, or they had a slight administrative report and were sent over to the CMS in a bulk process. This process will be updated so that any state that is an SBM in SERFF will have a new view that will allow it to submit the template information on certified plans over to the CMS. The work is almost completed, and it is anticipated that this will be the federal reporting process for plan year 2022. The second half of the plan management process is a new process that will take place this year, which is working with the Unified Rate Review template (URRT). Specific templates are not currently submitted on binders but are submitted on rate filings; a new validation and transfer process for the template will be developed with CMS on rate filings. Upon submission, whether it is a filing submission, amendment letter or a response letter, any updates to the URRT and additional supporting items, such as the actuarial justification or the consumer justification narrative, will automatically be sent to CMS. This will delete a duplicate process for issuers and will be more seamless. This new process will be in place in 2023.
Ms. Motter stated that in the last few weeks, she has seen occasions where it appears the new filing fee process has caused some confusion and wondered if some additional communication could be provided as incorrect amounts are being paid. She also asked if the issue with SERFF system delays that were experienced last week had been resolved. Ms. Woltkamp noted her team will work on some communication alerts and language to assist with making sure the correct state filing fees are being paid and not just the NAIC transaction fee, which is automatically assessed. She also stated that SERFF is aware of the system performance issue and that they are working with the database team to isolate, identify and correct any issues as quickly as possible. Ms. Woltkamp stated that as of this morning, it appeared performance levels were back to normal. However, she asked that anyone with continued issues let the SERFF team know.

Bridget Kieras (NAIC) stated that regarding the SERFF modernization project, the request for proposal (RFP) is in the final stage for the mobilization and pilot (wrapping up the vendor selection process, drafting the fiscal for project funding and beginning the work on the contract with the selected vendor). A press release will be sent out in the next few weeks announcing the vendor selection, as well as the kick-off of the project. She suggested reading the mobilization and pilot RFP, in particular the section on business objectives and the appendix with some use cases as these will be demonstrated during the pilot phase to ensure a solid architecture. She said that good tools were chosen to integrate with SERFF. She noted that work will also be done during the pilot to gather and document the business requirements and the new and improved features that will be offered. Communication plans are being drafted for the mobilization pilot phase to make sure there are lots of forms for users to provide input and get updates. One-on-one calls have started with state insurance regulators to provide SERFF modernization updates and expectations, as well as to gather information. One-on-one calls like this will not be arranged for the industry, but some other forms to provide project updates and expectations will be provided.

Theresa Boyce (Chubb Group) asked for additional details on the document Ms. Kieras suggested for review. Ms. Kieras said that an online search of SERFF Modernization RFP 2071 should provide a search result for the document, but she also provided the link to review it: https://content.naic.org/article/news_release_naic_releases_serff_modernization_rfp.htm.

5. Discussed the Annual Review of the PCM and UTD Suggestions

Ms. Motter stated one of the charges of this Working Group is to review any suggestions that are received throughout the year for proposed revisions to the Product Coding Matrix (PCM) and Uniform Transmittal Document (UTD). She noted that proposed revisions or changes can be submitted at any time throughout the year, but that an alert will be sent soon in SERFF reminding everyone that the deadline is May 31 for considerations to go in to effect for next year. The necessary meetings will be set up to discuss the suggestions after they are all reviewed to determine which revisions will be incorporated and then passed along for approval and implementation, which would take place in January. This past January, there were very few changes to the PCM. However, many suggestions were discussed, and alternative solutions were able to be provided. Ms. Motter asked that everyone, including state insurance regulators and industry members, provide any suggestions for consideration.

Having no further business, the Speed to Market (EX) Working Group adjourned.
COVID-19 Regulatory Relief or Regulatory Accommodations Related to Innovation and Technology

Request for Information – Spring Follow-Up

Introduction:

This document summarizes comments received from interested parties related to a follow up to the Request for Information sent prior to the NAIC Fall National Meeting. Those responses covered the following areas:

- Electronic Commerce
- Regulatory Capabilities
- Claims Facilitation
- Specific to Surplus Lines

This follow-up summary includes those same sections but reflects updated information the respondents noted or prioritized for the Innovation and Technology (EX) Task Force consideration.

Responses were received from the following organizations:

- American Council of Life Insurers (ACLI)
- American Property Casualty Insurance Association (APCIA)
- Lloyd’s
- McDermott Will & Emery (mwe)
- National Association of Professional Insurance Agents (PIA)
- Wholesale & Specialty Insurance Association (WSIA)

The following entities submitted responses in the fall but did not submit a response to this request:

- BlueCross BlueShield Association (BCBSA)
- Insured Retirement Institute (IRI)
- National Association of Mutual Insurance Companies (NAMIC)

Follow-Up Request:

Sent: March 3, 2021

Request to solicit comments from any interested party related to specific “regulatory relief” or “regulatory accommodations” related to innovation and technology

On behalf of the Task Force chair, Commissioner Godfread, and Vice Chair, Superintendent Dwyer, we are requesting your input where you believe these issues are interpretative versus what changes will need to be done legislatively. We ask that if you believe change must be done at the legislative level, please identify the law (or model law) impacted so the Task Force can address it more expeditiously. I believe it was mentioned during the meeting that some of that information has already been gathered and compiled, noting that it does involve a mix of legislation and interpretation, as well as federal overlay.

The ask is to break down your previous suggestions, if you can, and provide more specific information as to where the issues are more interpretative or lack a uniform interpretation, versus it being a legislative issue. Further if you have suggestions regarding prioritization of these issues as summarized in this document, those would be welcome.

The Task Force may also be interested in drafting a bulletin or bulletins as a solution, as suggested during the meeting. Both discussing and targeting more specific areas for attention and the bulletin concept will be discussed during the Task Force’s Spring Meeting on April 9, 1:00 pm CT.
Response Summary – Priorities:

Electronic Commerce

<table>
<thead>
<tr>
<th>Issue</th>
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<tbody>
<tr>
<td>1. Allow e-signatures</td>
<td>ACLI, mwe</td>
</tr>
<tr>
<td>2. Allow e-delivery</td>
<td>ACLI</td>
</tr>
<tr>
<td>3. Elimination notary requirements; allow e-notary</td>
<td>APCIA, mwe, PIA</td>
</tr>
<tr>
<td>4. Address “opt-in” requirements; change to “opt-out” for e-delivery</td>
<td>ACLI, APCIA</td>
</tr>
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</table>

Specific Action Suggestions:
ACLI: 1) Create a Working Group to examine e-commerce laws and regulations and “work toward meaningful, unified recommendations that are actionable by the NAIC.” 2) Survey states regarding UETA exceptions and then prioritize getting those exceptions eliminated.

APCIA: 1) Insurance departments should provide information to companies electronically. 2) Supports NCOIL’s efforts to move to Remote Online Notarization (RON) and specific to vehicle titling in a total loss claim situation.

Regulatory Capabilities

<table>
<thead>
<tr>
<th>Issue</th>
<th>Commented on by:</th>
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<tbody>
<tr>
<td>1. Education/Continuing Education: Eliminate in person classroom licensing requirements replaced with virtual or online options and eliminate or allow remote fingerprinting.</td>
<td>APCIA, PIA</td>
</tr>
<tr>
<td>2. Modify or eliminate proctor/monitor requirements for continuing education.</td>
<td>PIA</td>
</tr>
<tr>
<td>3. Authorize remote Workers’ Compensation hearings.</td>
<td>PIA</td>
</tr>
<tr>
<td>4. e-filings: eliminate hard copy regulatory filings or eliminate the need for a wet signature or traditional notarization for those filings.</td>
<td>Lloyd’s</td>
</tr>
<tr>
<td>5. Allow e-payment for all required regulatory fees such as premium taxes.</td>
<td>Lloyd’s, mwe</td>
</tr>
<tr>
<td>6. Eliminate wet signature requirements for regulatory filings such as biographical affidavits and certified reinsurer filings.</td>
<td>Lloyd’s, mwe</td>
</tr>
<tr>
<td>7. Expedite rate and form filing review following a pre-filing meeting.</td>
<td>mwe</td>
</tr>
<tr>
<td>8. Implement bulletins that alleviate the need for in-person MGA/TPA audits and allow virtual audits of employers and other similar requirements.</td>
<td>APCIA</td>
</tr>
<tr>
<td>9. Eliminate requirement for in person visit of physical office.</td>
<td>mwe</td>
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Specific Action Suggestions:
### Claims Facilitation

#### Key Points – from Fall National Meeting Comment Letters

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<thead>
<tr>
<th>Commented on by:</th>
<th>Key Points</th>
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<tbody>
<tr>
<td>Allow digital adjudication of claims including photo inspection particularly around auto inspections and allow non-licensed adjusters to be able to the photos.</td>
<td></td>
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<tr>
<td>Drones: Allow drones in adjusting including relaxing “fly beyond their line of sight” requirements.</td>
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<tr>
<td>Possibly draft legislation that would resolve concerns over “paper trail” liability related to certified letters for reservation of rights and coverage denials. The letter noted that there is no existing regulatory requirement to do this, but still concerns.</td>
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<tr>
<td>Allow remote/virtual administrative hearings to take place as well as video depositions.</td>
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<tr>
<td>Consider timing of electronic payments happening “at the same time” – proof of loss must be sent through the mail.</td>
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</table>
| **Telemedicine:** Allow this and relax in-person requirements.  
  - BCBSA suggests leveraging their existing “Guiding Principles for Telehealth” and allowing private insurers establish appropriate rules. |

#### Specific Action Suggestions:

<table>
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<tr>
<th>Issue</th>
<th>Commented on by:</th>
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<tbody>
<tr>
<td>1. Diligent Search: “on demand” product pricing is difficult due to the three-declination process in the current environment. Particularly where it must be documented and filed with the state. Should relax and automate this process.</td>
<td>Lloyd’s, mwe, WSIA</td>
</tr>
<tr>
<td>2. Expand export lists for coverages typically unavailable in the admitted market.</td>
<td>WSIA</td>
</tr>
<tr>
<td>3. Allow electronic tax payment and reporting options.</td>
<td>WSIA</td>
</tr>
<tr>
<td>4. Eliminate wet signature and notarization requirements on surplus lines reports.</td>
<td>WSIA</td>
</tr>
</tbody>
</table>

#### Specific to Surplus Lines

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<thead>
<tr>
<th>Issue</th>
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<tr>
<td><strong>Lloyd’s:</strong> 1) The Surplus Lines (C) Task Force is currently amending the relevant model law (Nonadmitted Insurance Model Act) pertaining to this issue so recommends this be deferred to that Task Force.</td>
<td></td>
</tr>
<tr>
<td><strong>WSIA:</strong> 1) WSIA provided a summary of related regulatory requirements by state.</td>
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</table>

Comments related to whether the recommended action is related to and interpretive, uniform interpretation or legislative type issue, were provided as were specific examples. The ACLI provided key purposes for a proposed bulletin that could address issues that do not appear to require a legislative change. Areas requiring a legislative change would either have to be taken up by the specific jurisdiction with the issue or addressed by an NAIC committee such as the Surplus Lines (C) Task Force.

Entities specifically noting it would support the drafting of a bulletin included:

- ACLI
- APCIA
- PIA

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LONG-TERM CARE INSURANCE (EX) TASK FORCE

Long-Term Care Insurance (EX) Task Force April 9, 2021, Minutes.............................................................4-179

Long-Term Care Insurance (EX) Task Force March 1, 2021, Minutes (Attachment One).................................4-182
The Long-Term Care Insurance (EX) Task Force met April 9, 2021. The following Task Force members participated: Scott A. White, Chair (VA); Michael Conway, Vice Chair, represented by Eric Unger (CO); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling (AL); Alan McClain represented by Jimmy Harris (AR); Evan G. Daniels represented by Jon Savary (AZ); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais (CT); Karima M. Woods represented by Philip Barlow (DC); David Altmaier represented by John Reilly (FL); Colin M. Hayashida (HI); Doug Ommen (IA); Dean L. Cameron (ID); Dana Popish Severingham represented by Leigh Strode (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt (KS); James J. Donelon (LA); Gary D. Anderson (MA); Eric A. Cioppa (ME); Anita G. Fox represented by Stephanie Francis (MI); Grace Arnold and Fred Andersen (MN); Chlora Lindley-Myers (MO); Mike Chaney (MS); Troy Downing (MT); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Matt Fischer (ND); Bruce R. Ramge and Rhonda Ahrens (NE); Marlene Caride represented by Dave Wolf (NJ); Russell Toal (NM); Barbara D. Richardson represented by Jack Childress (NV); Judith L. French (OH); Glen Mulready (OK); Andrew R. Stolfi represented by Tashia Sizemore (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer represented by Andrew Dvorine (SC); Larry D. Deiter (SD); Carter Lawrence (TN); Doug Slape (TX); Johnathan T. Pike (UT); Michael S. Pieciak represented by Emily Brown (VT); Mike Kreidler (WA); Mark Afable (WI); James A. Dodrill (WV); and Jeff Rude (WY).

1. **Adopted its March 1, 2021, and 2020 Fall National Meeting Minutes**

Commissioner White said the Task Force conducted an e-vote that concluded March 1 to adopt the 2021 proposed charges of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup.

Superintendent Toal made a motion, seconded by Commissioner Altman, to adopt the Task Force’s March 1, 2021 (Attachment One) and Dec. 4, 2020(see NAIC Proceedings – Fall 2020, Long-Term Care Insurance (EX) Task Force) minutes. The motion passed unanimously.

2. **Received the Report of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup**

Commissioner White said the Subgroup met March 9 and Feb. 25 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings, to give direction on the plan to draft a long-term care insurance (LTCI) multistate rate review framework and form a drafting group.

Commissioner White said the draft of the framework is divided between operational and actuarial aspects. The first draft that has been completed is the operational section. The drafting group will work on drafting the actuarial sections following today’s meeting. Ms. Ahrens summarized the operational sections of the draft framework.

a. Section I describes the purpose of the framework document, which relates to the goals of the Task Force; describes the multistate actuarial (MSA) rate review process, which is not an official rate filing; outlines states’ participation in the MSA review process; identifies the benefits of participating for both insurers and state insurance departments; describes the role of the Task Force; and outlines disclaimers and legal limitations of the review process and the MSA advisory report to address states’ legal concerns.

b. Section II describes the composition, qualifications, duties and commitment expectations for participation of MSA team members, as well as the authority and confidentiality of team members.

c. Section III describes the scope and size limits on rate proposals to be reviewed, as well as the process for how an insurer would make a request for a review of a rate proposal.

d. Section IV describes the MSA review process, which will use the infrastructure and support staff of the Interstate Insurance Product Regulation Commission (Compact). The section also describes an expected timeline for the MSA team members to follow in preparing and distributing an MSA advisory report to states.

e. The appendices provide for a template of the MSA advisory report for state insurance department regulators and a list of information that would be provided by the insurer for a complete rate proposal request.

Ted Nickel asked if states hire outside consultants for rate review, would the consultant be allowed to participate in the MSA rate review process. Ms. Ahrens said that regarding participation as an MSA team member performing the review, the
framework currently contemplates the team to be comprised of state insurance department staff that hold a senior position. Mr. Andersen said that regarding participation by other states, the process is intended to be open to all states. Mr. Andersen recommended submitting the comment on the exposure of the framework so that participation by a state’s hired consultant can be addressed in the framework.

Birny Birnbaum (Center for Economic Justice—CEJ) asked why the Compact could not be used for all LTCI rate filings. Superintendent Dwyer said the Compact only reviews LTCI rate increase filings that were originally filed with the Compact, which would exclude older blocks of business. The Compact only began accepting LTCI rates in 2011. She said inclusion of these older blocks would require a change to the Compact. Commissioner White said this framework for an MSA review process provides a mechanism to work through issues at this time. He said consideration of changes to the Compact would require discussion at a future time.

Mr. Andersen said the Subgroup’s pilot program review team has completed the review of several rate proposals from volunteer insurers. The review team is nearing completion of its review of the remaining rate proposals under the pilot program. He said the review team has made improvements with each review, which will help to transition to an MSA rate review process. An example of improvements is that the pilot program review team is providing volunteer companies with templates and supplementary documents to assist in them making an initial, complete rate proposal, which enhances timeliness and efficiency. The improvements will be formalized within the framework. He said companies that have interest in participating in the MSA rate review process can reach out to him or Ms. Ahrens but should note that resources may be limited at this time because the current focus is on drafting the framework.

Commissioner Donelon made a motion, seconded by Director Cameron, to receive the report of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup. The motion passed unanimously.

3. Exposed the Operational Section of the Multistate Rate Review Framework

Commissioner White said the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup formed a drafting group to develop the multistate rate review framework. The drafting group includes actuarial and legal state insurance department regulators and NAIC staff. The drafting of the framework was divided into two sections: 1) operational; and 2) actuarial. The drafting group has completed a draft of the operational topics, which will be exposed for a 45-day public comment period ending May 24. The drafting group will continue work on the actuarial portion of the framework, which is anticipated to be exposed for public comment by June 1.

4. Received the Report of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup

Commissioner Altman said the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup met March 24 and March 11 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings, to discuss plans to address its charges for this year. Commissioner Altman summarized the 2021 charges of the Subgroup. She said the Subgroup plans to meet in open session in early May to hear from industry members on current innovative long-term care (LTC) wellness pilot programs and hear stakeholder views of related regulatory issues that need to be addressed. The Subgroup will consider any efforts to address potential issues later in the year.

Commissioner Altman said regarding the charge to explore more uniformity in consumer notices of reduced benefit options (RBOs), the Subgroup will reevaluate a draft checklist for notices to consumers as it relates to the RBO Consumer Notices Principles that the Subgroup adopted in 2020.

Bonnie Burns (California Health Advocates—CHA) asked if state insurance regulators have looked at the timing of notices to policyholders. She said policyholders receive two notices—one with the rate increase and a second with RBOs—at different times, which creates confusion and difficulty for a consumer to make decisions. Commissioner Altman said this topic can be brought to the Subgroup during a future meeting.

Commissioner Dodrill made a motion, seconded by Commissioner Afable, to receive the report of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup. The motion passed unanimously.

Commissioner White said that with the exposure of the first draft of the multistate rate review framework and the expectation for the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup to begin addressing its charges in the near term, there will be more opportunity for input from interested parties.
5. **Heard a Presentation on LTCI Industry Trends**

Mr. Andersen said that through the work of the Valuation Analysis (E) Working Group and the review of *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) filings, industry trends have been identified that may affect LTCI reserve levels and rates. These factors include lower lapses, lower mortality, longer duration claims caused in part by a higher incidence of Alzheimer’s disease and dementia, as well as falling market interest rates, causing lower investment income opportunities on incoming premiums.

Mr. Andersen said some factors vary by company or are generally uncertain—for example, future benefit utilization. For companies with a lot of the 5% inflation protected business on the books, when cost of care inflation is lower than 5%, it tends to lead to benefit utilization less than 100% if the maximum daily benefit is increasing by 5%.

Mr. Andersen said another area that varies by company is morbidity incidents improvements. There are trends observed, or, in some cases, expectations that some of the aging at home, wellness activities and technology advances will create safer, healthier environments for seniors and lower claims. While an area of uncertainty, it may lead to lower morbidity incidents in the future.

Mr. Andersen said in the past, there has been a trend of past interest rates falling. The area of uncertainty is what is going to happen going forward. Last year, U.S. Treasury rates were in some cases below 1%, but the rates have increased, so there is a little more optimism. However, it is still uncertain how feature premiums and bond maturities will affect attainable investment yields.

Mr. Andersen said the Valuation Analysis (E) Working Group has engaged with domiciliary state insurance regulators and companies on uncertain areas that could affect their companies’ finances. He added that the Valuation Analysis (E) Working Group and the Financial Analysis (E) Working Group also coordinate on financial analysis.

6. **Discussed Other Matters**

Commissioner White reported that the Executive (EX) Committee referred the proposed project regarding the engagement of an outside legal consultant to assist the NAIC on matters relating to restructuring LTCI policies to the Restructuring Mechanisms (E) Working Group. The Restructuring Mechanisms (E) Working Group has been requested to report back to the Executive (EX) Committee in the fall, at which time it is anticipated that a decision will be made on the next steps for this project. Commissioners have expressed various concerns over the prospect of an LTC insurer seeking to separate blocks of business for any reason.

Commissioner White reported that the Task Force continues to work with the consultant that captured a special data call of insurers to quantify and evaluate the extent to which rates differ among states, because of state approval processes, to prepare a report suitable for the public.

Having no further business, the Long-Term Care Insurance (EX) Task Force adjourned.
The Long-Term Care Insurance (EX) Task Force conducted an e-vote that concluded March 1, 2021. The following Task Force members participated: Scott A. White, Chair (VA); Michael Conway, Vice Chair (CO); Lori K. Wing-Heier (AK); Jim L. Ridling represented by Steve Ostlund (AL); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Philip Barlow (DC); Trinidad Navarro represented by Frank Pyle (DE); Colin M. Hayashida (HI); Dana Popish Severinghaus represented by Jeff Varga (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt (KS); Anita G. Fox represented by Karen Dennis (MI); Grace Arnold (MN); Chlora Lindley-Myers (MO); Mike Causey represented by David Yetter (NC); Bruce R. Ramge represented by Rhonda Ahrens (NE); Russell Toal (NM); Judith L. French (OH); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer represented by Michael Wise (SC); Larry D. Deiter (SD); Carter Lawrence (TN); Johnathan T. Pike represented by Tanji J. Northrup (UT); Mike Kreidler (WA); Mark Afable (WI); James A. Dodrill represented by Joylynn Fix (WV); and Jeff Rude (WY).

1. **Adopted the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup’s 2021 Proposed Charges**

The Task Force conducted an e-vote to consider adoption of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup’s 2021 proposed charges. The motion passed with a majority of members voting in favor of adopting the charges. The Subgroup’s chair is Commissioner Jessica K. Altman (PA). The adopted charges are as follows:

The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup will:

A. Further evaluate and/or recommend options to help consumers manage the impact of rate increases. This includes:
   1. The potential development of a process to evaluate innovative options that allow for insurers to offer benefits that lessen the likelihood of an insured needing LTC services, including the evaluation of the suitability of and regulatory barriers to proposed options.
   2. The potential development of mechanisms to help state insurance regulators and consumers objectively compare reduced benefit options (RBOs), including the comparison of accepting a rate increase and retaining current benefits to electing offered RBOs.
   3. The further exploration of pursuing more uniformity in consumer notices for RBOs.

B. Support and provide expertise to the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup regarding the evaluation of RBOs.

Having no further business, the Long-Term Care Insurance (EX) Task Force adjourned.
SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE

Special (EX) Committee on Race and Insurance April 12, 2021, Minutes........................................................................................................4-184
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The Special (EX) Committee on Race and Insurance met April 12, 2021. The following members participated: David Altmaier, Co-Chair (FL); Dean L. Cameron, Co-Chair (ID); Raymond G. Farmer, Chair Emeritus (SC); Chlora Lindley-Myers, Co-Vice Chair (MO); Andrew N. Mais, Co-Vice Chair (CT); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Alan McClain (AR); Evan G. Daniels (AZ); Ricardo Lara (CA); Michael Conway (CO); Karima M. Woods (DC); Trinidad Navarro (DE); Colin M. Hayashida (HI); Doug Ommen (IA); Dana Popish Severyinghaus (IL); Stephen W. Robertson (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon (LA); Gary D. Anderson (MA); Eric A. Cioppa (ME); Kathleen A. Birrane (MD); Anita G. Fox (MI); Grace Arnold (MN); Mike Chaney (MS); Mike Causey represented by Jackie Obusek (NC); Jon Godfread (ND); Bruce R. Range represented by Martin Swanson (NE); Russell Toal (NM); Barbara D. Richardson (NV); Linda A. Lacewell represented by My Chi To (NY); Judith L. French (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Carter Lawrence (TN); Doug Slape (TX); Jonathan T. Pike (UT); Scott A. White (VA); Tregenza A. Roach (VI); Michael S. Picciak (VT); Mike Kreidler (WA); Mark Afable (WI); James A. Dodrill (WV); and Jeff Rude (WY).

1. Received a Report on Special Committee Activities

Commissioner Altmaier reported that the Special (EX) Committee on Race and Insurance established five workstreams to develop initial recommendations, and most of the work of the Special Committee has been done at the workstream level. All the workstreams, except for Workstream Two, which is looking internally at the NAIC and state insurance departments, held at least one open meeting as it conducted its initial work. The Special Committee met April 6 and March 24 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings, to receive those initial recommendations and determine where to place the continued work in the NAIC committee structure. The 2021 proposed charges (Attachment One) exposed for comment are the result of those initial consultations with staff. The Special Committee recognizes the quick turnaround for comments, and as noted when the proposed charges were released, additional commentary and engagement will certainly be necessary. The Special Committee is eager to continue a public dialogue on these important issues and appreciates the initial comments it has received, and it will discuss a more extensive comment period at the end of the meeting.

2. Received a Status Report on Workstream One

Executive Deputy Superintendent of Insurance To reported that Workstream One of the Special Committee was formed in September 2020, and it is co-chaired by Superintendent Cioppa and herself. Workstream One is charged with researching and analyzing the level of diversity and inclusion within the insurance industry and making recommendations on action steps.

In late February, Workstream One submitted its initial findings and preliminary recommendations on next steps to the Special Committee. Based on the initial research and engagement conducted by Workstream One, the Workstream has concluded that the insurance industry can and should do more to improve diversity and inclusion at all levels of its organizations, from corporate boardrooms and C-suites to middle-management and entry-level positions. This conclusion is based on information that the Workstream gathered through the collection and review of publicly available data, articles and studies, as well as comments submitted by industry representatives and other interested stakeholders.

Studies show that diversity is good for business, and one of the primary responsibilities of state insurance regulators is to ensure the financial stability of the insurers they oversee. Given the positive correlation of diversity and profitability, supporting the insurance industry’s diversity and inclusion efforts is consistent with that core mission, as well as the broader duty of the insurance sector to address racial inequalities and discrimination.

Workstream One believes that more work is required to develop specific recommendations of action steps that state insurance regulators and companies can take to improve the level of diversity and inclusion in the industry. Additional engagement with stakeholders and industry representatives is necessary to learn more about the initiatives and programs that have been deployed by insurance companies to recruit, retain and develop diverse talent at all levels. The Workstream also recognizes the need to measure progress, and it wants to learn more about how state insurance regulators can support that effort. The Workstream plans to continue its work and hold at least two additional open meetings in 2021.
Regarding process, Workstream One recommends that it continue in its present form at this time, and it will determine how best to proceed within the NAIC framework as part of its specific recommendations of action steps for state insurance regulators and the industry.

3. **Received a Status Report on Workstream Two**

Commissioner Clark reported that Workstream Two has two major components to investigate; diversity and inclusion within the NAIC and diversity and inclusion within state insurance departments. The Workstream is happy to report progress on both fronts. Commissioner Clark leads the subgroup on diversity and inclusion within state insurance departments.

The Workstream spent time as a group talking about the best way to collect information from its colleagues, and it developed a zone-based information gathering tool to capture state and department level diversity and inclusion best practices for consideration and implementation by its membership. The Workstream’s plan, if approved by the Special Committee and the Executive (EX) Committee, is to start gathering information shortly after the Spring National Meeting.

As stated in the Special Committee’s 2021 proposed charges, the Workstream will continue its work researching best practices among state insurance departments, and once it has gathered state and department level diversity and inclusion best practice information, it will continue to move its work forward by developing a method and forum to share this information among the states. Commissioner Clark asks that when the Workstream does reach out to state insurance departments, that they take the time to respond so the Workstream can start building a usable catalog of best practices to share with each other.

Commissioner Clark went on to report on the efforts of the subgroup on diversity and inclusion within the NAIC. The Workstream sent questions to the NAIC about its diversity, equity and inclusion (DE&I) efforts. The questions were based on the industry questions developed by Workstream One. In response, the NAIC submitted a written report, and the Workstream’s January meeting was dedicated to hearing from the NAIC about its efforts, particularly its focus on recruiting and retention.

The Workstream has identified several ways the NAIC can help with the DE&I efforts of the state insurance departments. Specifically, as staff diversity training is developed at the NAIC, consideration will be given to offering similar training at the state and/or zone level. Also, Evelyn Boswell (NAIC), Director of Diversity and Inclusion, will be working to collect diversity contacts from the states so the Workstream can get a forum established to share ideas and information.

As its work continues, and as stated in proposed committee charge D, Workstream Two in coordination with the Executive (EX) Committee will continue to receive reports on NAIC DE&I efforts to ensure that DE&I remains a top priority for the NAIC. The Workstream will also serve as the coordinating body for state requests for assistance from the NAIC related to DE&I.

4. **Received a Status Report on Workstream Three**

Commissioner Mais reported that Workstream Three was tasked with the charge dealing with property/casualty (P/C) insurance. In late 2020, the Workstream held three regulator-only meetings and one open meeting to hear various viewpoints on P/C issues related to its charge of examining practices and barriers that potentially disadvantage people of color and/or historically underrepresented groups.

The Workstream first developed an issues list to begin to scope out the project and receive information from interested parties. On its open call, it heard from six speakers who had signed up to speak, as well as a couple others. Consumer groups requested that the Workstream streamline its issues list and not “re-examine” known issues but focus on solutions. The consumer groups called for the Workstream to develop guidance for testing for disparate impact and collect additional data for market regulation purposes. The Workstream heard about how to work with external third parties to look for hidden biases in external databases. The industry stressed that education of consumers should be a focal point, and risk must not be neglected as the Workstream looks at issues of race.

On its last two regulator-only calls, the Workstream streamlined its issues list and came up with some more specific actions and charges for next steps, which were then reported to the Special Committee.

Commissioner Schmidt reported that the Workstream developed several major recommendations with subheadings for each. Those have been incorporated within the proposed charges.
For affordability, availability and access, the Workstream is asking that the NAIC and the Center for Insurance Policy and Research (CIPR) provide a status of studies concerning the affordability of auto and homeowners insurance, including a gap analysis of what has not been studied.

As part of this work, the Workstream recommends that state insurance regulators should determine steps that can be taken to mitigate the impact of residual markets, premium financing and nonstandard markets on disadvantaged groups.

For education and outreach, the Workstream seeks to develop ways to use education, outreach and consumer partnerships to improve access to underrepresented groups.

For producer issues, the Workstream asks for the Producer Licensing (D) Task Force to receive a report from NAIC staff on:

- Availability of producer licensing exams in foreign languages.
- Steps exam vendors have taken to mitigate cultural bias.
- Number and location of producers by company compared to demographics in the same area.

The issue of unfair discrimination is critical, and the Workstream recommends the development of analytical and regulatory tools to assist state insurance regulators in determining unfair discrimination, including issues related to:

- Use of socio-economic variables.
- Identifying proxy variables for race.
- Correlation vs. causation.
- Disparate impact considerations.
- Use of third-party data.
- Appropriateness of data, such as criminal history.

The Workstream also suggested exploring the possibility of the industry collecting data by race in order to better measure outcomes.

The Workstream also noted that it should work closely with existing groups, such as the Big Data and Artificial Intelligence (EX) Working Group and the Casualty Actuarial and Statistical (C) Task Force, as those groups continue their work in predictive modeling, price algorithms and artificial intelligence (AI) with a particular focus on how race is affected.

5. Received a Status Report on Workstream Four

Commissioner Afable reported that Workstream Four adopted its initial report and recommendations by e-vote on Feb. 5. The Workstream met Nov. 16, 2020, and Oct. 30, 2020, in regulator-to-regulator session, and Dec. 10, 2020, and Jan. 5 in open session.

During its open meetings, the Workstream heard presentations from a producer association, industry associations, an actuarial association, a financial educational institution, an insurance company, and a consumer representative. Each presentation brought to light different aspects of the complexities surrounding race and insurance in life insurance.

The primary conclusion of the Workstream was that it has only just started to delve into the practices and barriers that potentially disadvantage minority and underserved populations in the life insurance and annuity lines of business.

The Workstream recommends that research and discussions continue to: 1) better determine the practices or barriers that disadvantage people of color and/or historically underrepresented groups; and 2) identify steps that can be taken to eliminate those barriers and disadvantages.

The Workstream is willing to undertake this work to continue to research and formulate specific recommendations, as necessary, to address issues involving race and life insurance, such as:

a) The marketing, distribution and access to life insurance products in minority communities, including the role that financial literacy plays.

b) The impact of traditional life insurance underwriting on minority populations, considering the relationship between mortality risk and disparate impact.
c) Disparities in the number of cancellations/rescissions among minority policyholders.

d) Whether there are other unresolved issues surrounding race and insurance in the life insurance industry that the Workstream should consider addressing.

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

6. Received a Status Report on Workstream Five

Commissioner Lara reported that Workstream Five met Dec. 2, 2020, in open session and March 23, March 2 and Feb. 18 in regulator to-regulator session to prepare and finalize its initial report. Workstream Five finalized and adopted the report on March 23.

As its Dec. 2, 2020, meeting confirmed, and its initial report states, the Workstream believes access and network adequacy is an ongoing and persistent issue for people of color and/or historically underrepresented population groups. The Workstream also believes the other issues it has identified merit discussion and examination as well, including affordability. For these reasons, the Workstream plans to continue its work as its initial recommendations and the Special Committee’s 2021 proposed charges reflect.

Commissioner Altman highlighted a few of the Workstream’s initial recommendations. One recommendation it has is to conduct further research on measures to advance equity through lowering the cost of care and promoting access to care and coverage, with emphasis on people of color, low income and rural populations, and historically marginalized groups. The Workstream plans to focus this research on measures to remedy impacts on historically marginalized groups, as well as the examination of the use of network adequacy and provider directory measures to promote equitable access to culturally competent care.

The Workstream also recommends, in coordination with Workstreams One, Three and Four, developing a model data call to identify resources and products, including a product mix devoted or sold in specific zip codes.

The Workstream also recommends charging the Health Innovations (B) Working Group, consistent with its ongoing work, to evaluate mechanisms to resolve disparities and improve access to care, including: 1) the efficacy of telehealth as a mechanism for addressing access issues for people of color and low income and underrepresented groups; and 2) the use of advance payment models and the algorithms that power the underlying modeling and value-based payments and their impact on exacerbating or ameliorating disparities and social determinants of health.

Finally, another recommendation the Workstream has is for it to monitor opportunities and identify strategies for consumer education to address equity issues. The Workstream plans to make referrals, as appropriate, to the Consumer Information (B) Subgroup to develop educational materials after identifying areas and strategies it believes will help to increase awareness in communities of color and/or among other underrepresented groups.

7. Discussed its 2021 Proposed Charges and Heard Comments from Interested Parties

Commissioner Altmaier introduced the interested parties who submitted initial comments (Attachment Two) and requested to comment on the 2021 proposed charges of the Special Committee and other committee groups.

a. Thomas A. Campbell (American Academy of Actuaries—Academy) commented on behalf of the Academy and reiterated and reinforced the Academy’s previously stated commitment to work with the NAIC on the shared goal to address diversity and inclusion concerns pertaining to insurance coverages.

As communicated to the Special Committee upon its formation, the Academy is offering its ongoing assistance in the identification and exploration of areas where state insurance regulators can act in this regard and addressing practices that could create barriers, or conversely provide incentives, to the inclusion in insurance products. During the course of this work, Academy representatives have actively engaged the Special Committee, having made separate presentations to Workstreams Three, Four and Five on P/C, life, and health insurance issues, respectively. As the Special Committee moves forward on its newly proposed 2021 charges, the Academy stands ready to work with it on executing and implementing them. With the relatively recent posting of those charges, the Academy has not had the
full opportunity to assess them as yet, but it will provide input to the Special Committee, as appropriate, as its work progresses.

As the national actuarial association for public policy and professionalism in the U.S., the Academy is looking at issues surrounding the appropriateness of data and assumptions used in U.S. actuarial practice across all areas of practice and actively working with various stakeholders and within the actuarial profession to advance this objective. A sampling of the work the Academy is doing can be found on the Academy’s Diversity, Equity & Inclusion webpage. The Academy has formed task forces and work groups under its Casualty, Health, and Life Practice Councils that are dedicated to DE&I. The Academy also has an active process within its Risk Management and Financial Reporting Council on data analytics and algorithms, and it will be issuing papers on those topics shortly.

To further illustrate the emphasis of this work, Mr. Campbell would like to bring attention to a recent publication from the Academy with respect to health equity issues. The discussion brief, Health Equity from an Actuarial Perspective: Questions to Explore, issued by the Academy’s Health Equity Work Group, serves as an introduction to the Work Group’s approach to examining efforts to reduce health disparities and applying actuarial expertise to the following areas: health insurance benefit design, provider contracting and network development, premium pricing, and managing population health. As the Work Group’s chairperson, Annette James (Academy), has indicated, “[t]his foundational document on health equity issues begins by offering questions and topics for further exploration to help identify ways in which health benefit programs might affect health equity.” This is but the first offering from the Work Group; focused publications in each of the areas identified are expected to come forward in the near future. The Academy believes that charges relevant to the health workstream will relate to the ongoing work of the Work Group.

Finally, Mr. Campbell wanted to underscore the value the Academy places on the collaborative work with the NAIC that the Academy has enjoyed over the years on issues of mutual interest. On this initiative and the many other workstreams in which the Special Committee is actively working on at the NAIC, the Academy is committed to providing objective expert actuarial analysis on behalf of the U.S. actuarial profession.

b. Angela Gleason (American Property Casualty Insurance Association—APCIA) stated that the APCIA remains committed to constructive partnership with all stakeholders to advance meaningful solution-driven dialogue aimed at sustainable proposals that benefit all. The APCIA looks forward to providing specific recommendations to the Special Committee’s 2021 proposed charges, but it offers foundational observations into the deep thinking that it continues to exercise around race and insurance issues.

These are broad and complicated historical issues, so the solutions are not simple and will require time to craft meaningful change. In the letter the APCIA submitted, APCIA chief executive officer (CEO) Dr. David Sampson stresses that the core purpose of the insurance industry is to provide sustainable risk transfer and risk mitigation solutions for our customers at a price commensurate with their actual or expected losses. Doing so ensures an equitable cost to each customer while also protecting the solvency of the insurance industry.

In light of those fundamental principles, the APCIA identified two important areas where it believes there are omissions from the preliminary draft charges. First, there does not appear to be a reference to researching and analyzing underlying cost drivers and how the industry can assist in addressing these issues. Long-standing forward-thinking solutions to historical challenges necessitate consideration of the lost cost drivers. Second, the issue of economic empowerment has been a consistent and important consideration throughout the NAIC dialogue, and the APCIA would like to see that topic referenced more strongly.

The draft 2021 charges of the Special Committee reflect much of the broad thinking and wide analysis required for the insurance sector to meaningfully grapple with these issues. Promoting DE&I at every level of the company and throughout the supply chain is paramount, and the APCIA looks forward to partnering with and sharing information with state insurance regulators on this topic. However, the APCIA is concerned that the same approach to analysis is not carried through in some of the underlying tone and drafting in some of the Workstream Three, Four and Five changes. For instance, Special Committee charges include continuing research and analysis of the legal and regulatory approaches to addressing unfair discrimination, but they simultaneously presuppose the outcome of that research and analysis, directing the development of tools and definitions without any foundational consideration of the problem trying to be solved. To drive collaboration and consensus toward meaningful change, state insurance regulators and stakeholders must reach consensus on the current legal framework and where that framework presents opportunities for change. Without that threshold exercise, when reaching consensus, there is the risk of going down the wrong path and developing solutions that do not address the problem. The APCIA believes there could be a benefit to some
language about taking a sequenced approach to first prioritizing the analysis of the current legal and regulatory framework. Specific to research, the APCIA will have some recommendations consistent with utilizing data that is available and meaningful.

Ms. Gleason turned it over to Roosevelt Mosley, principal and consulting actuary with Pinnacle Actuarial Resources, to highlight why reaching consensus on the legal framework and next steps matters. She thanked the Special Committee for the opportunity to share these thoughts, and the APCIA looks forward to continuing this important partnership.

c. Roosevelt Mosley (Pinnacle Actuarial Resources) commented on the implication of the proposed charges as they relate to setting rates for P/C insurance. Pinnacle Actuarial Resources recognizes that this is a very important issue that must be addressed, and it is in full support of the work of the Special Committee and being involved in assisting in whatever way possible.

Ultimately, Pinnacle Actuarial Resources believes that the collaboration between insurance companies, legislators, state insurance regulators, and consumer representatives will develop a solution that maintains the right balance between cost-based pricing and equity and fairness in terms of rates.

Secondly, Pinnacle Actuarial Resources also supports the research-based approach that is being advocated and recommends that the Special Committee continue to focus on defining what the issues are and evaluating solutions that will potentially address the issue and lead to the intended desired results.

Pinnacle Actuarial Resources believes this will require taking a holistic approach to this issue; this is not an issue that is going to be necessarily addressed by eliminating one rating factor, or even particularly one potential group of rating factors because the issue is more nuanced than that. Therefore, Pinnacle Actuarial Resources would encourage the Special Committee to continue to focus on research to ensure that the issue is being defined properly and then continue that research to evaluate the effects of proposed solutions so that they do not create any unintended consequences.

The other issue Pinnacle Actuarial Resources would like to draw attention to is the issue of correlation versus causation, particularly from an actuarial perspective. The actuarial standards on the use of risk classification factors do not require causation, but they do state that a logical relationship to expected outcomes is desirable but is not necessarily required. Putting a requirement of causation on particular risk characteristics could be significantly challenging, and Pinnacle Actuarial Resources would respectfully request that the Special Committee carefully consider the idea of correlation versus causation.

Lastly, Pinnacle Actuarial Resources applauds and encourages the Special Committee's separate listing of affordability of insurance versus the fairness of rates and bias.

For the insurance process to work efficiently for the maximum benefits of customers and insurers, the fundamentals of cost-based insurance must be maintained and must be appropriately balanced with the fact that rates should be fair and unbiased.

d. Birny Birnbaum (Center for Economic Justice—CEJ) stated, “CEJ greatly appreciates the efforts of the Special (EX) Committee on Race and Insurance and the NAIC to fully engage and examine the insurance impacts of systemic racism on communities of color. The proposed charges reflect a serious and sustained commitment by the members of the NAIC to identify and eliminate racism in insurance and to improve diversity, equity and inclusion among regulators and insurers.”

The CEJ’s review of the proposed charges suggests that the charges can be significantly improved for clarity; coordination; reducing overlapping activities; and most importantly, a more systematic approach to the issue. The CEJ sees the following problems with the charges:

- The charges seem to be more of a wish list of activities than a systematic approach to examining and addressing issues of race and insurance.
- The charges range from specific tasks to broad investigations with no distinction about the breadth of the activity.
- The charges largely fail to specify deliverables or time frames for delivery.
The charges create structures through Special Committee workstreams that duplicate lettered committee responsibilities and that make coordination unnecessarily difficult.

The charges reflect an initial cut at identifying insurer policies and practices that may result in disparate impact or proxy discrimination, but they contain no provision for a comprehensive examination by the subject matter committees.

The charges do not include key components of a comprehensive and systematic approach to examining race in insurance, including the identification of public policies that unfairly disadvantage communities of color or improving diversity and inclusion by consumer stakeholders, generally, and communities of color, particularly in regulatory processes.

The CEJ’s comments of March 23 to the Special Committee discuss the need for and components of a comprehensive and systematic approach by the NAIC to examine the effects of systemic racism in insurance. The CEJ has summarized its review of the suggested revisions to the proposed charges into the chart included with its comment letter. The chart shows the major strategic components, the specific charges for specific NAIC committees, the specific deliverables, and the time frame for deliverables.

The CEJ also recommends significant streamlining of the many Special Committee workstreams into one working group for the DE&I efforts and the remaining activities either at the Special Committee level or in a Special Committee Legal and Regulatory Guidance working group combined with assignments to other NAIC committees. This streamlining will reduce unnecessary duplication, facilitate coordination, better engage subject matter experts (SMEs) within the letter committees and better allow consumer stakeholder participation. It is much more difficult for consumer stakeholders to meaningfully participate when the relevant activities are spread over so many different workstreams and committees because of the much more limited resources of consumer stakeholders compared to industry stakeholders.

The CEJ suggests that a comprehensive and systematic approach by the NAIC to addressing race in insurance has five major components:

1. **DE&I among insurers, state insurance regulators, and consumer stakeholders in NAIC and regulatory processes.** The proposed Special Committee charges address the first two groups, but there is no charge for DE&I for communities of color in regulatory processes. The CEJ suggests that the Special Committee efforts for DE&I be combined into a single working group of the Special Committee and that the NAIC/Consumer Liaison Committee be charged with developing recommendations for improving DE&I within regulatory processes.

2. **Analyze, affirm and develop, as necessary, the legal and policy framework for addressing race and insurance.** This set of activities is the foundation for identifying and addressing the structural and systemic causes of racial disparities in insurance. The main deliverable is definitions of disparate impact and proxy discrimination. These definitions will reflect the intent of state insurance regulators and provide the guiding principles for the remaining activities. This work should be the responsibility of the Special Committee.

3. **Develop the legal and regulatory guidance for implementing the policy framework for race and insurance and implementing the Principles for AI.** This component of the overall strategy includes:
   a. Guidance for insurers to test for disparate impact and proxy discrimination.
   b. Guidance for insurers to report test results and actions taken in response to test results.
   c. Guidance for safe harbors for insurers who follow regulatory guidance.
   d. Guidance for insurers to implement the NAIC Principles for AI.

   The first three charges should be assigned to Special Committee, while the last charge should be assigned to the Big Data and Artificial Intelligence (EX) Working Group.

4. **Develop tools and resources for regulatory oversight.** This is the component of the overall strategy that ensures that state insurance regulators have the resources, tools, data and skills to effectively implement the regulatory guidance. Key tasks within this component are:
   a. Develop market regulation data collection sufficient to monitor consumer market outcomes by prohibited class characteristics.
b. Identify gaps in regulatory skills and resources necessary for the analysis of disparate impact and proxy discrimination.

The CEJ suggests that these charges be assigned to the Market Regulation and Consumer Affairs (D) Committee for several reasons. First, the proposed charges have this activity assigned to three workstreams, creating repetitive efforts. This should be a unified activity because the types of data and analysis necessary to examine accelerated underwriting in life insurance for disparate impact and proxy discrimination are the same as those necessary to examine health insurance delivery outcomes, personal auto claim settlements, homeowners pricing, or marketing for small business owners insurance. Second, the D Committee is already where consumer market outcome data collection efforts are housed. Third, it is the market regulators who will likely be carrying the bulk of responsibility for analyzing policies and practices for disparate impact and proxy discrimination. While the CEJ has great respect for the actuaries who review rate filings, it is not actuarial expertise that is relevant for examining disparate impact and proxy discrimination.

5. **Identify industry practices and public policies that may produce disparate impact and proxy discrimination.** The proposed charges include many specific inquiries for Workstreams Three, Four and Five for the CIPR. It is unclear how this list of issues of concern was developed or what equity framework was used to prioritize the listed items. Further, the list fails to distinguish between industry practices (subject to regulatory oversight) versus public policies (outside of regulatory oversight) that may lead to disparate impact and proxy discrimination. This is a critical distinction, and both lines of inquiry are essential to address systemic racism in insurance.

The CEJ suggests that instead of assigning this effort to Special Committee workstreams, the assignment to identify and examine practices and policies that may disadvantage communities of color should be assigned to the subject matter committees. It makes no sense to have a Special Committee workstream look at these issues for P/C insurance when the NAIC has a P/C committee. Moreover, assigning just the proposed charges to the three workstreams produces both major gaps and duplication. It produces gaps because there is no workstream that tracks the work of the Market Regulation and Consumer Affairs (D) Committee or the Financial Condition (E) Committee.

The CEJ also recommends that the charge to identify industry practices and public policies that produce disparate impact and proxy discrimination be given to the Financial Condition (E) Committee. It is vital that state insurance regulators and insurers examine their investment practices to identify investments that encourage or support environmental racism or abusive racial practices. For example, if state insurance regulators and insurers are committed to addressing systemic racism in insurance, then insurers should not be investing in predatory lenders or other businesses that systematically rob.

In closing, the CEJ asks for the Special Committee’s consideration of its suggested changes to the charges. The CEJ’s changes will better organize your efforts and, more importantly, facilitate stakeholder engagement. The CEJ looks forward to constructive engagement with other stakeholders and NAIC members to achieve concrete outcomes that match the anti-racism statements of industry and state insurance regulators.

e. Tony Cotto (National Association of Mutual Insurance Companies—NAMIC) commented that although the NAIC and its members have faced unique operational challenges this year, those challenges should not be used as an all-encompassing shield to avoid transparency and establish open collaborative NAIC processes.

When the Special Committee was formed, NAMIC and its members pledged to be partners in good faith at the table for all the discussions of the important issues to be tackled at the intersection of race and insurance. NAMIC provided initial recommendations to focus on issues surrounding the talent pipeline, and it is very glad to see that as one of the new proposed charges.

At the same time, NAMIC is deeply concerned that while it is sitting at the table ready to work together, the Special Committee’s work to date has largely taken place behind closed doors, with minimal time and opportunity for meaningful input.

The lengthy proposed charges that NAMIC had less than 72 hours to respond to include several significant substantive presumptions that, at the very least, merit additional discussion prior to adoption.
In a number of places, problems are assumed as something needing to be addressed or mitigated. Instead, NAMIC believes that the Special Committee should first determine if there is enough proof to answer a threshold question; it is not how to address the problem, but it is whether the problem exists at all. The proposed charges further introduce concepts that are foreign to state insurance codes and regulatory authority because they are fundamentally incompatible with sound risk classification, risk-based pricing, and established principles of unfair discrimination, like disparate impact and causal requirements for rating factors. Additionally, suggesting enhanced data reporting and requiring insurers to collect race and other socio-demographic data that insurers are not interested in and consumers do not like to provide is also likely to run afoul of numerous state and federal laws.

NAMIC’s members know that, like its regulators and the communities it serves, they are all stronger when NAMIC leverages and includes diverse backgrounds, skills, knowledge and perspectives of its policyholders, vendors and employees. At the same time, NAMIC respectfully discourages the use of departments or insurance (DOIs) regulation as tools for social engineering to fix societal problems that have nothing to do with insurance.

As NAMIC considers what it can and should do together within the bounds of the insurance ecosystem and its governing laws, Mr. Cotto encouraged not elevating demographics over data. Instead, he suggested focusing on what can be accomplished by working together to improve access for all stakeholders to the insurance mechanism and all of the economic empowerment that comes with that access.

f. Sonja Larkin-Thorne (Consumer Advocate) thanked the NAIC for the work and commitment on this issue.

Ms. Larkin-Thorne stated that Dr. Rochelle Walensky, Director of the U.S. Centers for Disease Control and Prevention (CDC), described racism as a serious public health threat that directly affects the well-being of millions of Americans; as a result, it affects the health of the entire nation. Racism is not just the discrimination against one group based upon the color of their skin or their race or ethnicity, but the structural barriers that affect racial and ethnic groups differently to influence where a person lives, where they work, where their children play, and where they worship and gather in community. The social determinants have a long-term negative effect on the mental and physical health of individuals and their communities and on their ability to live beyond certain communities and categories in life.

Ms. Larkin-Thorne noted that as the NAIC struggles to talk about race and insurance, it must be acknowledged that the business of insurance is the very foundation and the stability of the American economic system, but she does question why this system excludes so many Americans just trying to achieve the American dream. Ms. Larkin-Thorne questions whether there is something that is inherent in the fabric of the insurance industry that it has not been able to attract and retain diverse talent.

Ms. Larkin-Thorne noted that now everybody is bringing a person of color to the table to represent them. She believes insurance company CEOs need to come to the table and talk instead of sending their talking heads. They need to come to the table and listen about what is being seen and heard and help develop a plan that addresses the concerns that consumers have brought to attention.

After the comments, Commissioner Altmaier responded to concerns that the Special Committee has not been transparent with this process; certainly some regulator-only discussions have occurred, as they do on many of its workstreams in the past. As the Special Committee has stated multiple times, it will continue being transparent with this process and engaging with all of its stakeholders across the spectrum of the insurance industry. The Special Committee looks forward to everyone's participation in this going forward.

Commissioner Lara noted his frustration with the comments made by some associations that represent the industry. Commissioner Lara said he finds it a little disheartening that the Special Committee is trying to work with the industry and all the parties involved, and some of these organizations are still not even acknowledging or taking responsibility for what the industry has done in the past. It remains impossible to get to a point of actually having fruitful and transparent discussions if these organizations are not fully ready to acknowledge that everyone has this responsibility and the insurance industry also has a responsibility moving forward.

Commissioner Conway echoed Commissioner Lara’s comments and thanked the NAIC leadership for leading the charge and ensuring that the Special Committee keeps focused on these issues.

Commissioner Ommen also thanked the NAIC for continuing to work on these really important issues, and he appreciates all of the comments that have been received and the information that is continuing to be gathered.
Commissioner Ommen also noted the Special Committee needs to continue to be honest and recognize the actual causes of the disparities that are in the marketplace. Government policies, educational and economic differences contribute to the underlying social, safety and health risks that affect communities of color, especially urban communities of color. The Special Committee must think about and to some degree contribute to the ongoing discussions that are occurring outside of our industry.

Commissioner Altman stated that many are at the table with statements about putting in the hard work and having the hard conversations. She agrees with the sentiments about the NAIC, the current leadership, the former leadership, and the regulatory community really stepping up. The 2021 proposed charges are indicative of that willingness for the regulatory community to put the work in. Commissioner Altman says she hopes the stakeholders will be the Special Committee’s partners and will do the work with it and have a willingness to have those hard conversations and not just push back on them because they are hard.

Commissioner Navarro echoed Commissioner Lara’s comment on his disappointment from the industry and comments. He would have loved to have heard them say they want to work with the state insurance regulators; agree that issues around credit score, lack of credit, marital status and education exist; and state that they are no longer going to use those because they know they are unfairly discriminatory. He said he did not hear anyone say that, and when the Special Committee tried locally to address those in both private auto and homeowners insurance, guests lined up against the state insurance regulators to fight this initiative in the legislature. The Special Committee asked to see the correlation between credit score and claims history, and the data just simply was not available. The Special Committee appreciates its interaction with the industry, but Commissioner Navarro believes they can do more.

Commissioner Altmaier noted that the Special Committee will expose its 2021 proposed charges for a 30-day public comment period ending May 14 to receive detailed commentary on the proposed charges, followed by a public meeting of the Special Committee to fully consider stakeholder comments and finalize the 2021 work plan and charges.

Director Cameron noted that he appreciates the comments made by his fellow commissioners and interested parties. It certainly leads to the understanding of how difficult this task is and how much work has to be done. Director Cameron said he wants to assure the industry that the Special Committee intends to be collaborative. He also cautioned that the Special Committee is going to ask everyone to step up, just as it is asking itself to step up and lead.

The Special Committee has to provide confidence to its consumers that it is not providing any sort of discrimination and that it is not participating either intentionally or unintentionally with any form of discrimination. Director Farmer knew when he started this process in 2020 that this would not be a short, rushed change in direction, but rather a change in direction that will take years to accomplish. The Special Committee intends to move in that direction to reach that consensus and urge others to work with it. The Special Committee looks forward to having those conversations and talking to others individually and collectively as we move forward.

Director Fox suggested that those interested parties who presented comments on the proposed charges provide specific language for consideration, specifically where there is discussion on correlation and causation and not just comments about what is inadequate.

Having no further business, the Special (EX) Committee on Race and Insurance adjourned.
Special (EX) Committee on Race and Insurance

The Special (EX) Committee on Race and Insurance will:

A. Serve as the NAIC’s coordinating body on issues related to (i) diversity and inclusion within the insurance sector; (ii) race, diversity, and inclusion in access to the insurance sector and insurance products; and (iii) practices within the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups.

B. Coordinate with existing groups such as the Big Data and Artificial Intelligence (EX) Working Group and the Casualty Actuarial and Statistical (C) Task Force and encourage those groups to continue their work in predictive modeling, price algorithms and artificial intelligence (AI), with a particular focus on how race is impacted.

C. (Workstream One) Continue research and analysis to develop specific recommendations on action steps that state insurance regulators and companies can take to improve the level of diversity and inclusion in the industry, including:
   1. Seek additional engagement from stakeholders to understand the efficacy of diversity-related programs, how companies measure their progress and what state insurance regulators can do to support these efforts.
   2. Collect input on existing gaps in available industry diversity-related data.

D. (Workstream Two) In coordination with the Executive (EX) Committee, receive reports on NAIC diversity, equity and inclusion (DE&I) efforts. Serve as the coordinating body for state requests for assistance from the NAIC related to DE&I efforts.

E. (Workstream Two) Research best practices among state insurance departments on DE&I efforts and develop forums for sharing relevant information among states.

F. Continue research and analysis of insurance, legal and regulatory approaches to addressing unfair discrimination, specifically proxy discrimination and disparate impact, by defining the terms and determining appropriate steps to address, including:
   1. (Workstream Four) The impact of traditional life insurance underwriting on minority populations, considering the relationship between mortality risk and disparate impact.
   2. (Workstream Three) Developing analytical and regulatory tools to assist state insurance regulators in determining unfair discrimination including issues related to:
      a. The use of socioeconomic variables.
      b. Identifying proxy variables for race.
      c. Correlation vs. causation.
      d. Disparate impact considerations.
      e. Use of third-party data.
      f. Appropriateness of data such as criminal history.

G. (Workstreams Three, Four and Five) Consider enhanced data reporting and record-keeping requirements across product lines to identify race and other sociodemographic factors of insureds. Consider a data call to identify resources and products sold in specific ZIP codes to identify barriers to access.

H. Continue research and analysis related to insurance access and affordability issues, including:
   1. (Workstream Four) The marketing, distribution and access to life insurance products in minority communities, including the role that financial literacy plays.
   2. (Workstream Four) Disparities in the number of cancellations/rescissions among minority policyholders.
   3. (Workstream Five) Measures to advance equity through lowering the cost of health care and promoting access to care and coverage, with specific focus on measures to remedy impacts on people of color, low income and rural populations, and historically marginalized groups, such as the LGBTQ+ community, individuals with disabilities, and Alaska Native and other Native and Indigenous people.
   4. (Workstream Five) Examination of the use of network adequacy and provider directory measures (such as provider diversity, language and cultural competence) to promote equitable access to culturally competent care.
   5. (Workstream Five) Conduct additional outreach to educate consumers and collect information on health and health care complaints related to discrimination and inequities in accessing care.
   6. (Workstream Three) Steps that can be taken to mitigate the impact of residual markets, premium financing and nonstandard markets on disadvantaged groups.
   7. Make referrals for the development of consumer education and outreach materials as appropriate.
I. Direct NAIC and Center for Insurance Policy and Research (CIPR) staff to conduct necessary research and analysis, including:
   1. (Workstream Three) The status of studies concerning the affordability of auto and homeowner’s insurance, including a gap analysis of what has not been studied.
   2. (Workstream Three) The availability of producer licensing exams in foreign languages, steps exam vendors have taken to mitigate cultural bias, and the number and locations of producers by company compared to demographics in the same area.
   3. (Workstream Five) Aggregation of existing research on health care disparities and collection of insurance responses to the COVID-19 pandemic and its impact across demographic populations.

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE – NEW CHARGES

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

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

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

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

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

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

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

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April 9, 2021

Honorable David Altmaier, Co-Chair
Honorable Dean L. Cameron, Co-Chair
Special (EX) Committee on Race and Insurance
National Association of Insurance Commissioners

Dear Commissioner Altmaier and Director Cameron:

On behalf of the American Academy of Actuaries,¹ I wish to reiterate and reinforce our previously stated commitment to work with the National Association of Insurance Commissioners on our shared goal to address diversity and inclusion concerns pertaining to insurance coverages.

As communicated to the committee upon its formation, the Academy is offering its ongoing assistance to you in your identification and exploration of areas where regulators can act in this regard and to address practices that could create barriers, or conversely provide incentives, to inclusion in insurance products. During the course of this work, Academy representatives have actively engaged the special committee, having made separate presentations to its workstreams three, four and five, on property/casualty, life, and health insurance issues, respectively. As you move forward on your newly proposed 2021 charges, we stand ready to work with you on executing and implementing them. With the relatively recent posting of those charges we have not had full opportunity to assess them as yet, but will provide input to you as appropriate as your work progresses.

As the national actuarial association for public policy and professionalism in the United States, the Academy is looking at issues surrounding appropriateness of data and assumptions used in U.S. actuarial practice across all areas of practice and is actively working with various

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
stakeholders and within the actuarial profession to advance this objective. A sampling of the work the Academy is doing can be found on the Academy’s Diversity, Equity & Inclusion webpage. We have formed task forces and work groups under our Casualty, Health, and Life Practice Councils that are dedicated to diversity, equity, and inclusion. We also have an active process within our Risk Management and Financial Reporting Council on data analytics and algorithms and will be issuing papers on those topics shortly.

To further illustrate the emphasis of this work, I would like to bring to your attention a recent publication from the Academy with respect to health equity issues. The discussion brief, Health Equity From an Actuarial Perspective: Questions to Explore, issued by the Academy’s Health Equity Work Group, serves as an introduction to the work group’s approach to examining efforts to reduce health disparities and applying actuarial expertise to the following areas: health insurance benefit design, provider contracting and network development, premium pricing, and managing population health. As the work group’s chairperson, Annette James, has indicated, “This foundational document on health equity issues begins by offering questions and topics for further exploration to help identify ways in which health benefit programs might affect health equity.” This is but the first offering from this work group; focused publications in each of the areas identified are expected to come forward in the near future. We do think that charges relevant to the health workstream will relate to the ongoing work of our Health Equity Work Group.

Finally, I want to underscore the value the Academy places on the collaborative work with the NAIC that we have enjoyed over the years on issues of mutual interest. On this initiative and the many other workstreams in which we are actively working on at the NAIC, we are committed to providing objective expert actuarial analysis on behalf of the U.S. actuarial profession.

If you have any questions regarding these comments that you would like to discuss, please feel free to contact me or Craig Hanna, the Academy’s director of public policy, at hanna@actuary.org.

Sincerely,

Thomas A. Campbell
President
American Academy of Actuaries

Cc: Andrew J. Beal, Michael F. Consedine, Kay Noonan
April 9, 2021

Commissioner David Altmaier, Co-Chair
Director Dean Cameron, Co-Chair
NAIC Special Committee on Race and Insurance
National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 700
Washington, D.C. 20001-1512

Forwarded via email to: Kay Noonan, KNoonan@NAIC.org

RE: NAIC Special (EX) Committee on Race and Insurance 2021 Charges

Dear Commissioner Altmaier and Director Cameron:

On behalf of our member plans, we would like to thank you for the opportunity to review the 2021 Proposed Charges to the Special (EX) Committee on Race and Insurance in advance of the meeting in April 12.

AHIP continues to support this critically important work and we stand ready to partner with the Special Committee on Race and Insurance and Committees to develop frameworks for measurable action. Health insurance providers are committed to achieving health equity, and believe that every American deserves access to affordable, high-quality care and health coverage, regardless of race, color, national origin, gender, sex, sexual orientation, age, or disability. Members of minority communities have a long history of being underserved and under-represented, resulting in persistent discrimination and systemic racism, which have exacerbated inequality in our health care system and negatively impacted the health and wellbeing of the individual members of these minority communities.

In September 2020, AHIP provided detail on key actions AHIP member plans are taking to improve health equity across our communities and among the more than 200 million Americans they serve. As of April 8th, we have also launched a resource page devoted to this work highlighting that health insurance providers continue this fight with recent areas of focus which include:

- **Listening to Leaders.** Fighting for health equity begins with listening. As part of our Health Equity Spotlight, AHIP talked with a diverse group of health care leaders to better understand the challenges facing minority and underserved communities and how we can work together to effect change.

- **Serving Communities in Need.** Health insurance providers have been working with federal, state, and local leaders to ensure Americans can get vaccinated as quickly and equitably as possible. Through the Vaccine Community Connectors initiative, health insurance providers have committed to promote health equity by enabling the vaccination of 2 million seniors age 65+ in America’s communities that are most at-risk and underserved — such as African American and Hispanic communities.
Taking Decisive Action. Achieving health equity means addressing factors that go beyond “traditional” health care. In fact, many social barriers in everyday life play a large role in personal health and health outcomes. These factors include limited access to healthy foods, reliable transportation, or health care services, as well as unsafe or unstable housing. Health insurance providers are working hard every day to break down these barriers. Free dental care, grants to address systemic racism, and donations to help with housing stability are just a few of the many actions health insurance providers are taking to address social determinants of health.

Everyone in America has the right to live their best, healthiest life. Health insurance providers are committed to fighting for health equity and improving health outcomes for every Americans.

With respect to the 2021 proposed charges of the Special (EX) Committee on Race and Insurance, we look forward to a discussion and more thorough review of the proposed scope and focus of this year’s work both during and following the April 12 meeting. We will remain active and engaged on the following areas outlined in the proposed charges:

- predictive modeling, price algorithms and artificial intelligence (AI), with a particular focus on how race is impacted.
- insurance, legal and regulatory approaches to addressing unfair discrimination, specifically proxy discrimination and disparate impact, by defining the terms and determining appropriate steps to address.
- data reporting and record-keeping requirements across product lines to identify race and other sociodemographic factors of insureds.
- insurance access and affordability issues, including educating consumers and collecting information on health and health care complaints related to discrimination and inequities in accessing care; and
- aggregation of existing research on health care disparities and collection of insurance responses to the COVID-19 pandemic and its impact across demographic populations.

We express our ongoing appreciation for the NAIC’s willingness to undertake this effort, and we continue to look forward to working with you to address these issues in a meaningful and productive way.

Sincerely yours,

Miranda Motter
MMotter@AHIP.org
202-923-7246
VIA EMAIL TRANSMISSION

April 11, 2021

Commissioner David Altmaier and Director Dean L. Cameron
Co-Chairs, Special (EX) Committee on Race and Insurance
National Association of Insurance Commissioner
1100 Walnut Street, Suite 1500
Kansas City, MO 6410

Via Electronic Mail: knoonan@naic.org

RE: 2021 Proposed Charges – Special (EX) Committee on Race and Insurance

Dear Commissioner Altmaier and Director Cameron:

The American Property Casualty Insurance Association (APCIA) remains committed to constructive partnership with all stakeholders to advance meaningful solution-driven dialogue aimed at sustainable proposals that benefit all. We look forward to providing specific recommendations to the Special Committee (EX) on Race and Insurance’s proposed charges in the coming days, but offer foundational observations into the deep thinking that we continue to exercise around race and insurance issues.

The societal issues of today are long-standing and have been with our nation in some form since the founding of our Republic. Mellody Hobson, Co-CEO and President of Ariel Investments and Chairperson of the Board for Starbucks describes this period of “time as ‘Civil Rights 3.0’ – 1.0 representing the time after enslaved people were freed by the Emancipation Proclamation, and 2.0 being the 1960s, when societal momentum helped pass the Civil Rights Act and the Voting Rights Act. ‘The difference between then and now, this problem, this issue is at the feet of corporate America,’ Hobson says. ‘Now, corporate America is being held accountable in a very different way than we’ve ever seen before, by people inside the companies, by customers, by the broader society.’” (Michael Ko, “New Starbucks board chair lives, leads with urgency,” March 19, 2021 (quoting Mellody Hobson), available at https://stories.starbucks.com/stories/2021/new-starbucks-board-chair-mellody-hobson-lives-leads-with-urgency/).

These are broad and complicated historical issues, so the solutions are not simple and will require time to craft meaningful change. Importantly, these conversations must remain grounded in the core purpose of the insurance industry, which is to enable economic empowerment through sustainable risk transfer and risk mitigation solutions for our customers at a price commensurate with their actual or expected losses. Doing so ensures an equitable cost to each customer while also protecting the solvency of the insurance industry.
That is our core competency as an industry and anything that undermines our ability to deliver that fundamental value proposition also undermines the purpose of insurance.

This means some challenges may not lend themselves to insurance-specific solutions but will require the business community, government partners, and consumer groups to collaborate on holistic approaches that allow all to reach their highest economic potential. It also means that stakeholders will need to thoroughly understand the specific societal problems that need to be addressed and the current applicable regulatory and legal standards before requirements are imposed that could undermine both the fundamental risk-based pricing foundation of insurance and the ability to address the specific problem at issue.

APCIA’s Board Working Group on Social Equity and Inclusion Issues meets regularly to discuss these broad societal issues and the role of the insurance industry as well as opportunities to enhance diversity in our own companies and supply chains. APCIA is a founding member of the Insurance Careers Movement, we just concluded another successful joint Diversity Equity and Inclusion conference with the American Council of Life Insurers (ACLI) and Life Insurance Council of New York (LICONY). APCIA worked with Aon’s Ward Group and Plus Ultre to develop a Diversity and Inclusion Catalog (DEI Catalog). The DEI Catalog is an anonymized census of DEI policies, programs, and practices of APCIA member companies that will be updated biannually to benchmark and inform our industry improvements. APCIA renews its offer to present the Catalog findings to regulators.

The Draft 2021 Charges of the NAIC’s Special Committee On Race and Insurance Reflect much of the broad thinking and wide analysis required for the insurance sector to meaningfully grapple with these issues. The draft would, however, benefit from a wider discussion of its contents with an eye on possible additions or improvements. Economic empowerment issues and strategies, impacting loss costs, and a recognition of the need to receive input from regulators, consumers, and the industry are just a few examples for inclusion.

Thank you for the opportunity to share these thoughts and we look forward to continuing our important partnership with you.

Sincerely,

David A. Sampson
April 9, 2021

Commissioner David Altmaier, Co-Chair  
Director Dean Cameron, Co-Chair  
Special Committee on Race and Insurance  
National Association of Insurance Commissioners  
444 North Capitol Street NW, Suite 700  
Washington, D.C. 20001-1512

Submitted electronically to: Kay Noonan (knoonan@naic.org)

Dear Commissioner Altmaier and Director Cameron:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide preliminary comments on the proposed charges for 2021 to the Special (EX) Committee on Race and Insurance (Special Committee) and related charges to other committee groups. BCBSA supports the continued efforts of the Special Committee to advance diversity and inclusion and address racial disparities that disadvantage people of color and historically underrepresented communities.

BCBSA is a national federation of 35 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans) that collectively provide health care coverage for one in three Americans. For more than 90 years, Blue Cross and Blue Shield companies have offered quality health care coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

BCBSA believes everyone should have access to high-quality health care regardless of race, ethnicity, national origin, sex, gender identity, sexual orientation, religion, education level, age, geography or disability. We understand the need to recognize the impact of long-standing structures of racism and discrimination, underlying bias and social factors on the health and well-being of many Americans. To that end, every BCBS company across the country, including in Puerto Rico, has launched at least one local initiative to address health disparities.

Our Issue Brief, *Addressing Health Disparities and Inequities in Communities of Color*, identifies five essential steps to creating a more equitable health system:

- Use data to uncover the most critical opportunities to drive health equity
• Target interventions to specific conditions that are chronic and plague communities of color
• Improve access to health coverage
• Address social determinants of health
• Increase the number of racially and ethnically diverse clinicians and provide training to all physicians that enables them to deliver culturally appropriate care

Our policy recommendations align with the Special Committee’s proposed 2021 charges and efforts to promote improved access to coverage and affordable culturally competent care.

Data

We agree that quality and accurate data is a key element to improving health equity in all communities across the country. Consistent race, ethnicity and language (REL) data collection standards should be implemented across the industry to avoid inaccuracies and inconsistencies. Currently, there are many variances in federal and state laws governing REL data collection in the healthcare sector. REL data sets come from different sources (i.e., provider records, employer records, member-provided information and imputation algorithms) and are collected using varying standards, which has an impact on their accuracy, consistency and completeness. We encourage the Special Committee to keep this in mind when finalizing its charges and recognize that any initial data calls will be challenged by these inconsistencies until standards can be implemented across the industry.

Access to Coverage

Research shows that people of color are more likely to be uninsured. BCBSA recommends several key actions to reduce inequities in access to coverage, including making permanent the enhancements to the ACA subsidies recently included in the American Recovery Plan Act, continuing to incentivize Medicaid expansion, automatically enrolling individuals in available coverage and removing barriers preventing immigrants from accessing necessary care.

Behavioral Health

To improve behavioral health care for people of color, there is an urgent need for individuals to have access to high-quality mental health services. To meaningfully address existing barriers to access and quality we must focus on the root causes – the limited availability of providers in communities of color, the critical need to reduce underlying disparities exacerbated by the stigmatization of mental health in underserved communities, and institutional biases meeting patients’ needs. These issues are critical to improving the health of people of color and reducing disparities in care. We are committed to ensuring compliance with mental health parity laws, but these laws and regulations focus on parity across types of services rather than across communities and cultural barriers, and alone cannot address the need to address provider shortages and systemic issues that hinder access for communities of color.

COVID-19

To date, BCBS companies have collectively committed more than $7 billion to fight the COVID-19 pandemic. As part of this commitment, we believe that everyone deserves access to safe, effective COVID-19 vaccines to protect themselves, their families and their communities. That is why we joined America’s Health Insurance Plans (AHIP) in a new White House initiative to promote health equity by removing barriers to vaccinations for 2 million Americans most at risk of COVID-19. The Vaccine Community Connectors pilot initiative aims to enable the vaccination of 2 million seniors age 65+ in America’s most at-risk, vulnerable and underserved communities – such as African American and Hispanic communities.
BCBSA and a broad range of other stakeholders have provided input into the development of the workstream reports on race and insurance. We appreciate the NAIC’s thoughtful consideration of those previous comments in developing the reports. We look forward to partnering with the Special Committee as it seeks industry input and technical expertise on this important topic. If you have any questions or want additional information, please contact Randi Chapman at randi.chapman@bcbsa.com or 202.826.5156.

Sincerely,

[Signature]

Senior Vice President
Office of Policy and Representation
Comments from the Center for Economic Justice

To the NAIC (EX) Committee on Race and Insurance

April 10, 2021

The Center for Economic Justice (CEJ) submits the following comments on the 2021 Proposed Charges for the Special (EX) Committee on Race and Insurance (“SCoRI”) released on April 7, 2021. Our comments reference our March 23, 2021 comments to the SCoRI and our April 8, 2021 Consumer Liaison Committee presentation, both attached.

CEJ greatly appreciates the efforts of the SCoRI and the NAIC to fully engage and examine the insurance impacts of systemic racism on communities of color. The proposed charges reflect a serious and sustained commitment by the members of the NAIC to identify and eliminate racism in insurance and to improve diversity, equity and inclusion among regulators and insurers.

Our review of the proposed charges suggests that the charges can be significantly improved for clarity, coordination, reducing overlapping activities and, most importantly, a more systematic approach to the issue. We see the following problems with the charges.

- The charges seem to be more of a wish list of activities than a systematic approach to examining and addressing issues of race and insurance.
- The charges range from specific tasks to broad investigations with no distinction about the breadth of the activity.
- There charges largely fail to specify deliverables or time frames for delivery.
- The charges create structures through SCoRI work streams that duplicate lettered Committee responsibilities and that make coordination unnecessarily difficult.
- The charges reflect an initial cut at identifying insurer policies and practices that may result in disparate impact or proxy discrimination, but contain no provision for a comprehensive examination by the subject-matter committees.
- The charges do not include key components of a comprehensive and systematic approach to examining race in insurance, including identification of public policies that unfairly disadvantage communities of color or improving diversity and inclusion by consumer stakeholders, generally, and communities of color, particularly in regulatory processes.

Our comments of March 23, 2021 to the SCoRI discuss the need for and components of a comprehensive and systematic approach by the NAIC to examine the impacts of systemic racism in insurance. We have summarized our review of the proposed charges suggested revisions into the chart below. The chart shows the major strategic components, the specific charges for specific NAIC committees, the specific deliverables and the time frame for deliverables.
We also recommend significant streamlining of the many SCoRI work streams into one working group for the DE&I efforts and the remaining activities either at the SCoRI committee level or in a SCoRI Legal and Regulatory Guidance working group combined with assignments to other NAIC Committees. This streamlining will reduce unnecessary duplication, facilitate coordination, better engage subject-matter experts within the lettered committees and better allow consumer stakeholder participation. It is much more difficult to consumer stakeholder to meaningfully participate when the relevant activities are spread over so many different work streams and committees because of the much more limited resources of consumer stakeholders compared to industry stakeholders.

We suggest a comprehensive and systematic approach by the NAIC to addressing race in insurance has five major components. Please see the chart for a summary.

1. **Diversity, Equity and Inclusion (“DE&I”) among insurers, regulators and consumer stakeholders in NAIC and regulatory processes.** The proposed SCoRI charges C, D and E address the first two groups, but there is no charge for DE&I for communities of color in regulatory processes. We suggest the SCoRI efforts for DE&I be combined into a single working group of the SCoRI and that the Consumer Liaison Committee be charged with developing recommendations for improving DE&I within regulatory processes.

2. **Analyze, affirm and develop, as necessary, the legal and policy framework for addressing race and insurance.** This set of activities is the foundation for identifying and addressing the structural and systemic causes of racial disparities in insurance. The main deliverable is definitions of disparate impact and proxy discrimination. These definitions will reflect the intent of regulators and will provide the guiding principles for the remaining activities. This work should be the responsibility of the SCoRI.

3. **Develop the legal and regulatory guidance for implementing the policy framework for race and insurance and for implementing the Principles for AI.** This component of the overall strategy includes:
   
   a. Guidance for insurers to test for disparate impact and proxy discrimination;
   
   b. Guidance for insurers to report test results and actions taken in response to test results
   
   c. Guidance for safe harbors for insurers who follow regulatory guidance
   
   d. Guidance insurers to implement the NAIC Principles for AI

   Charges a, b and c should be assigned to SCoRI, while charge d should be assigned to the Big Data / AI working group.
4. **Develop tools and resources for regulatory oversight.** This is the component of the overall strategy that ensures that regulators have the resources, tools, data and skills to effectively implement the regulatory guidance. Key tasks within this component are:

   a. Develop market regulation data collection sufficient to monitor consumer market outcomes by prohibited class characteristics; and

   b. Identify gaps in regulatory skills and resources necessary analysis of disparate impact and proxy discrimination.

We suggest that these charges be assigned to the Market Regulation (D) Committee for several reasons. First, the proposed charges have this activity assigned to three work streams (in proposed charge G), creating repetitive efforts. This should be a unified activity because the types of data and analysis necessary to examine accelerated underwriting in life insurance for disparate impact and proxy discrimination are the same as those necessary to examine health insurance delivery outcomes or personal auto claim settlements or homeowners pricing or marketing for small business owners insurance. Second, the Market Regulation (D) Committee is already where consumer market outcome data collection efforts are housed. Third, it is the market regulators who will likely be carrying the bulk of responsibility for analyzing policies and practices for disparate impact and proxy discrimination. While we have great respect for the actuaries who review rate filings, it is not actuarial expertise that is relevant for examining disparate impact and proxy discrimination.

5. **Identify industry practices and public policies that may produce disparate impact and proxy discrimination.** The proposed charges include many specific inquiries for work streams 3, 4 and 5 for the CIPR. It is unclear how this list of issues of concern was developed or what equity framework was used to prioritize the listed items. Further, the list fails to distinguish between industry practices (subject to regulatory oversight) versus public policies (outside of regulatory oversight) that may lead to disparate impact and proxy discrimination. This is a critical distinction and both lines of inquiry are essential to address systemic racism in insurance.

For example, let’s look at uninsured motorist issues. Standard industry practice is to develop sub-state rating territories for uninsured motorist coverage rates. But, we know that the uninsured motorist rate is higher in communities of color for a variety of reasons tied to historic racial discrimination. By using sub-state rating territories for UM rates, consumers in communities of color who purchase UM are penalized because there is a higher percentage of community members unable to afford insurance. This is essentially a penalty for living in a community of color. Regulators currently have authority to identify such rating practices as unfairly discriminatory – an example of an industry practice that may result in disparate impact or proxy discrimination.
CEJ Comments to NAIC Special Committee on Race and Insurance  
April 10, 2021  
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For an example of public policy that likely creates disparate impact, the Property / Casualty C Committee could look at states’ efforts to enforce financial responsibility laws and identify and punish uninsured drivers. If these increasingly intensive and data-driven monitoring and enforce efforts disproportionately punish members of communities of color, insurance regulators should provide analysis and insight to policymakers to address the uninsured motorist problem without creating a debtors’ prison for communities of color.

We suggest that instead of assigning this effort to SCoRI work streams, the assignment to identify and examine practices and policies that may disadvantage communities of color be assigned to the subject matter committees. It makes no sense to have a SCoRI work stream look at these issues for property/casualty insurance when the NAIC has a property/casualty committee. Moreover, assigning just the proposed charges to the three work streams produces both major gaps and duplication. It produces gaps because there is no work stream that tracks the work of the Market Regulation D or Financial Condition E Committees.

Our attached March 23, 2021 comments to the SCoRI and attached April 8, 2021 presentation to the Consumer Liaison Committee show that insurer practices for marketing, claims settlement and antifraud raise as much or more concern regarding potential racial disparities and exclusion than pricing. Most of these non-pricing industry practices are part of the D Committee’s portfolio and, consequently, the D Committee should be just as much a “work stream” for the effort to examine racial disparities as the major lines of business – and that work should be done at the lettered committee and not in a parallel and duplicative “work stream” of SCoRI.

We also recommend that the charge to identify industry practices and public policies that produce disparate impact and proxy discrimination be given to the Financial Condition E Committee. It is vital that regulators and insurers examine their investment practices to identify investments that encourage or support environmental racism or abusive racial practices. For example, if regulators and insurers are committed to addressing systemic racism in insurance, then insurers should not be investing in predatory lenders or other businesses that systematically rob

In closing, we look forward to constructive engagement with other stakeholders and NAIC members to achieve concrete outcomes that match the anti-racism statements of industry and regulators. We also urge the SCoRI to provide a two-week comment period following your April 12, 2021 meeting for comments by interested parties, followed by a public meeting of the SCoRI by the end for April or beginning of May to fully consider stakeholder comments and finalize the 2021 work plan and charges..
### CEJ Proposed 2021 Strategy and Charges for NAIC Special Committee on Race and Insurance

<table>
<thead>
<tr>
<th>Major Strategic Activity</th>
<th>Specific Activity</th>
<th>Responsible Committee</th>
<th>Deliverable</th>
<th>Time Frame</th>
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<tbody>
<tr>
<td><strong>Affirm the Legal and Policy Framework for Addressing Race and Insurance</strong></td>
<td></td>
<td>Race and Insurance</td>
<td>Definitions</td>
<td>Draft by 7/15/2021, Final by Fall National Meeting</td>
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<tr>
<td></td>
<td>Guidance for Insurers to Respond to Test Results</td>
<td>Race and Insurance</td>
<td>Guidance</td>
<td>Draft by Summer 2021 National Meeting, Final by Fall 2021 National Meeting</td>
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<td>Guidance for Report Test Results</td>
<td>Guidance</td>
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<td>Guidance for Safe Harbors for Insurers to Follow Guidance</td>
<td>Race and Insurance</td>
<td>Guidance</td>
<td>Draft by Summer 2021 National Meeting, Final by Fall 2021 National Meeting</td>
</tr>
<tr>
<td></td>
<td>Guidance for Insurers to Implement NAIC Principles for AI</td>
<td>Big Data / AI</td>
<td>Guidance</td>
<td>Draft by Fall 2021 National Meeting, Final by Spring 2022 National Meeting</td>
</tr>
<tr>
<td><strong>Develop Tools and Resources for Regulatory Oversight</strong></td>
<td></td>
<td>Market Regulation D</td>
<td>Proposed Statistical Plan and Data Reporting Infrastructure</td>
<td>Draft by Summer 2021 National Meeting, Final by Fall 2021 National Meeting</td>
</tr>
<tr>
<td></td>
<td>Identify Gaps in Regulatory Skills and Resources Necessary for Analysis of Disparate Impact and Proxy Discrimination</td>
<td>Market Regulation D</td>
<td>Assessment of Current and Needed Regulatory Skills and Resources</td>
<td>Fall 2021 National Meeting</td>
</tr>
</tbody>
</table>

**Summary**

- **Promote Diversity, Equity and Inclusion in Insurance**
  - Within Insurers, Producers and Suppliers
  - Within Insurers
  - Within Regulators
  - Within Regulatory Processes

- **Affirm the Legal and Policy Framework for Addressing Race and Insurance**

- **Develop Legal and Regulatory Guidance for Implementing Policy Framework for Race and Insurance and for Implementing Principles for AI**

- **Develop Tools and Resources for Regulatory Oversight**

- **Identify Industry Practices and Public Policies That May Produce Disparate Impact and Proxy Discrimination, Including Low-Value Products That Target Communities of Color**
  - Add Charge for A, B, C, D, E Committees
  - Life Insurance, Health B, Property/Casualty C, Market Regulation D, Financial Condition E, D Committee to focus on insurer marketing, claims settlement and antifraud. E Committee to focus on insurer investments that promote or discourage environmental racism, predatory lending and other business practices that disadvantage
Regulatory Modernization to Address Systemic Racism in Insurance

Presentation to NAIC Consumer Liaison Committee

April 8, 2021

Birny Birnbaum
Center for Economic Justice
The Center for Economic Justice

CEJ is a non-profit consumer advocacy organization dedicated to representing the interests of low-income and minority consumers as a class on economic justice issues. Most of our work is before administrative agencies on insurance, financial services and utility issues.

On the Web: www.cej-online.org
About Birny Birnbaum

Birny Birnbaum is the Director of the Center for Economic Justice, a non-profit organization whose mission is to advocate on behalf of low-income consumers on issues of availability, affordability, accessibility of basic goods and services, such as utilities, credit and insurance.

Birny, an economist and former insurance regulator, has worked on racial justice issues for 30 years. He performed the first insurance redlining studies in Texas in 1991 and since then has conducted numerous studies and analyses of racial bias in insurance for consumer and public organizations. He has served for many years as a designated Consumer Representative at the National Association of Insurance Commissioners and is a member of the U.S. Department of Treasury’s Federal Advisory Committee on Insurance, where he co-chairs the subcommittee on insurance availability. Birny is also a member of the U.S. Federal Reserve Board’s Insurance Policy Advisory Committee.

Birny served as Associate Commissioner for Policy and Research and the Chief Economist at the Texas Department of Insurance. At the Department, Birny developed and implemented a robust data collection program for market monitoring and surveillance.

Birny was educated at Bowdoin College and the Massachusetts Institute of Technology. He holds Master's Degrees from MIT in Management and in Urban Planning with concentrations is finance and applied economics. He holds the AMCM certification.
Why CEJ Works on Insurance Issues


CEJ works to ensure *fair access* and *fair treatment* for insurance consumers, particularly for low- and moderate-income consumers.

*Insurance is the Primary Institution to Promote Loss Prevention and Mitigation, Resiliency and Sustainability:*

CEJ works to ensure insurance institutions maximize their role in efforts to reduce loss of life and property from catastrophic events and to *promote resiliency and sustainability* of individuals, businesses and communities.
What Information Does This Map of Omaha Nebraska Present?

a. Concentration of Minority Population?
b. Concentration of Flood Risk?
c. Concentration of Policing Activities?
d. Concentration of Rates of COVID Infections and Deaths?
e. Concentration of Home Ownership Rates?
f. Concentration of Family Wealth?
g. Federal Home Loan Eligibility 1930’s to 1960’s?
Systemic Racism\(^1\)

“Structural racism is the policies and practices that normalize and legalize racism in a way that creates differential access to goods, services, and opportunities based on race,” the report says. “Environmental racism refers to policies, practices, or directives that result in advantages or disadvantages to individuals or communities based on race.” Furthermore, environmental racism includes harm caused by infrastructures that determine access and quality of resources and services.

“To understand environmental racism in the United States, we must discuss the nation’s history of housing policies and the ways they have impacted Black people,” the report says. Those policies include zoning ordinances, restrictive covenants, blockbusting, steer ring and redlining. It defines redlining as a practice used by the Federal Housing Administration to outline Black neighborhoods with red, making them ineligible for federally insured loans, according to the rating system used by the Home Owners’ Loan Corporation.
How Can Systemic Racism Manifest Itself in Insurance – Whether for Marketing, Pricing or Claims Settlement?

1. Intentional Use of Race – Disparate Intent

2. Disproportionate Outcomes Tied to Historic Discrimination and Embedded in Insurance Outcomes – Disparate Impact

3. Disproportionate Outcomes Tied to Use of Proxies for Race, Not to Outcomes – Proxy Discrimination
The Evolution of Insurers’ Analytics: Univariate to Multivariate Analysis

In the past 30 years, insurers have moved away from univariate analysis to multivariate analysis – from analyzing the effects of one risk characteristic at a time to simultaneous analysis of many risk characteristics.

What the problem with univariate analysis?

If I analyze the relationship of age, gender and credit score – each individually – to the likelihood of a claim, the individual results for each risk characteristic are likely capturing some of the effects of the other risk characteristics – because age, gender and credit score (or other risk classifications) may be correlated to each other as well as to the outcome variable.

How does multi-variate analysis address this problem?
Testing for Disparate Impact and Proxy Discrimination:
A Natural Extension of Typical Insurer Practices

Here’s a simple illustration of a multivariate model. Let’s create a simple model to predict the likelihood of an auto claim:

\[ b_0 + b_1X_1 + b_2X_2 + b_3X_3 + e = y \]

\( X_1, X_2 + X_3 \) are the predictive variables trying to predict \( y \).

Say that \( X_1, X_2 + X_3 \) are age, gender and credit score and we are trying to predict \( y \) – the likelihood of an auto insurance claim.

Let’s assume that all three \( X \)s are statistically significant predictors of the likelihood of a claim and the \( b \) values are how much each \( X \) contributes to the explanation of claim. The \( b \) values can be tested for statistical significance – how reliable are these estimates of the contribution of each \( X \)?

**By analyzing these predictive variable simultaneously, the model removes the correlation among the predictive variables.**
Use of Control Variables in Multivariate Insurance Models

Suppose an insurer want to control for certain factors that might distort the analysis? For example, an insurer developing a national pricing model would might want to control for different state effects like different age distributions, different occupation mixes, different frequencies of accidents or differences in jurisprudence. An insurer would add one or more control variables.

\[ b_0 + b_1X_1 + b_2X_2 + b_3X_3 + b_4C_1 + e = y \]

\( C_1 \) is a control variable – let’s say for State. By including State as a control variable, the correlation of the Xs to State is statistically removed and the new b values are now the contribution of the Xs, independent of their correlation to State, to explaining the likelihood of a claim. When the insurer deploys the model, it still only uses the X variables, but now with more accurate b values.
Disparate Impact as Both a Standard and a Methodology

Let’s go back to multi-variate model, but now use Race as a control variable:

\[ b_0 + b_1X_1 + b_2X_2 + b_3X_3 + b_4R_1 + e = y \]

\( R_1 \) is a control variable – by including race in the model development, the correlation of the Xs to race is statistically removed and the new b values are now the contribution of the Xs, independent of their correlation to race, to explaining the likelihood of a claim.

What if \( X_1 \) is a perfect proxy for Race?

Then once we add the control variable for Race, \( X_1 \) no longer has any predictive value because all it was doing was predicting race, not the outcome \( y \).

What if \( X_1 \) is both predictive of mortality and correlated to Race? Then, the model still shows \( X_1 \)’s (now different) predictive value, but shorn of its correlation to Race, leaving the unique contribution of \( X_1 \) to explaining mortality.
How Do We Interpret the Disparate Impact Analysis?

\[ b_0 + b_1X_1 + b_2X_2 + b_3X_3 + b_4R_1 + e = y \]

Result: No Proxy Discrimination or Disparate Impact

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Interpretation</th>
<th>Indicated Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>R is not statistically significant and there is little change to b1, b2 and b3.</td>
<td>There is little correlation between X1, X2 and X3 and race, little or no disparate impact or proxy discrimination</td>
<td>None, utilize the model.</td>
</tr>
</tbody>
</table>
How Do We Interpret the Disparate Impact Analysis?

\[ b_0 + b_1X_1 + b_2X_2 + b_3X_3 + b_4R_1 + e = y \]

Result: Proxy Discrimination

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Interpretation</th>
<th>Indicated Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>R is statistically significant and ( b_1 ) has lost its statistical significance</td>
<td>X1 was largely a proxy for race and the original predictive value of X1 was spurious. <strong>This is an example of proxy discrimination</strong></td>
<td>Remove X1 from the marketing, pricing, claims settlement or anti-fraud model.</td>
</tr>
</tbody>
</table>
**How Do We Interpret the Disparate Impact Analysis?**

\[ b_0 + b_1X_1 + b_2X_2 + b_3X_3 + b_4R_1 + e = y \]

**Result:** Disparate Impact

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Interpretation</th>
<th>Indicated Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>R is statistically significant and has a large impact on</td>
<td>This is an example of disparate impact.</td>
<td>Are X1, X2 or X3 essential for the insurer’s business purposes? Are there less discriminatory approaches available? Would eliminating a predictive variable significantly reduce the disparate impact but not materially affect the efficiency or productiveness of the model?</td>
</tr>
<tr>
<td>the outcome, but b1, b2 and b3 remain largely unchanged</td>
<td></td>
<td></td>
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<tr>
<td>and statistically significant</td>
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How Do We Interpret the Disparate Impact Analysis?

\[ b_0 + b_1X_1 + b_2X_2 + b_3X_3 + b_4R_1 + e = y \]

Result: Some Proxy Discrimination, Some Disparate Impact

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Interpretation</th>
<th>Indicated Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>R is statistically significant, but b1, b2 and b3 remain statistically significant with different values from the original.</td>
<td>X1, X2 and X3 are correlated to race, but also predictive of the outcome, even after removing the variables’ correlation to race. This is an example of some proxy discrimination and some disparate impact.</td>
<td>Depending on the significance of the racial impact, utilize the model with the revised predictive variable coefficients, consider prohibiting a variable on the basis of equity or both.</td>
</tr>
</tbody>
</table>
Disparate Impact Analysis Improves Cost-Based Pricing

There is a long history and many approaches to identifying and minimizing disparate impact in employment, credit and insurance. But, the general principle is to identify and remove the correlations between the protected class characteristic and the predictive variables.

\[ b_0 + b_1X_1 + b_2X_2 + b_3X_3 + b_4R_1 + e = y \]

What if \(X_1, X_2\) and \(X_3\) are not perfect proxies for Race, but still have high correlation? Then, the disparate impact analysis – and our simple model – removes that correlation and the remaining values for \(b_1, b_2\) and \(b_3\) are the unique contributions of each predictive variable to explaining the outcome. The result is more – not less – accurate cost-based or risk-based analysis.
Why is it Reasonable and Necessary to Recognize Disparate Impact as Unfair Discrimination in Insurance?

1. It makes no sense to permit insurers to do indirectly what they are prohibited from doing directly. If we don’t want insurers to discriminate on the basis of race, why would we ignore practices that have the same effect?

2. It improves risk-based and cost-based practices.

3. In an era of Big Data, systemic racism means that there are no “facially-neutral” factors.
What Did We Learn from the Coded Bias Movie?

Advocates of algorithmic techniques like data mining argue that they eliminate human biases from the decision-making process. **But an algorithm is only as good as the data it works with.** Data mining can inherit the prejudices of prior decision-makers or reflect the widespread biases that persist in society at large. **Often, the “patterns” it discovers are simply preexisting societal patterns of inequality and exclusion. Unthinking reliance on data mining can deny members of vulnerable groups full participation in society.**

The fact that an insurer doesn’t use race in an algorithm does not logically or factually result in no discrimination on the basis of race.

In fact, the only way to identify and eliminate the impacts of structural racism in insurance is to measure that impact by explicit consideration of race and other protected class factors.
Defining Disparate Impact and Proxy Discrimination in Insurance

*Disparate Impact:* Use of a non-prohibited factor that causes disproportionate outcomes on the basis of prohibited class membership and that such disproportionate outcomes cannot be eliminated or reduced without compromising the risk-based framework of insurance.

*Proxy Discrimination:* Use of a non-prohibited factor that, due in whole or in part to a significant correlation with a prohibited class characteristic, causes unnecessary, disproportionate outcomes on the basis of prohibited class membership.
How Should These Definitions Be Implemented?


2. Create a Safe Harbor for Insurers Who Do This Using Methods Accepted by Regulators.

3. Establish Equity Standards for Minimizing Disparate Impact:
   a. Seek approaches that reduce disparate impact without compromising efficiency of the algorithm; and
   b. Establish an equity/efficiency trade off of 20 to 1: For example, reduce algorithmic efficiency by 2% if disparate impact can be reduced by 40% or more.
The Murder of George Floyd Raised Awareness of Systemic Racism
How Did Insurer CEOs React?

“In the coming days, I encourage each of us to step outside of our comfort zones, seek to understand, engage in productive conversations and hold ourselves accountable for being part of the solution. We must forever stamp out racism and discrimination.” Those are the words of Kirt Walker, Chief Executive Officer of Nationwide.

Floyd’s death in Minneapolis is the latest example of “a broken society, fueled by a variety of factors but all connected by inherent bias and systemic racism. Society must take action on multiple levels and in new ways. It also requires people of privilege—white people—to stand up for and stand with our communities like we never have before,” Those are the words of Jack Salzwedel, the CEO of American Family.
How Have the Insurer Trades – Particularly NAMIC and APCIA – Responded to the Insurer CEOs’ Calls?

- Opposed the inclusion of “Consistent with the risk-based foundation of insurance, AI actors should proactively . . . avoid proxy discrimination against protected classes.”

- Have opposed the application of disparate impact liability under the federal Fair Housing Act to home insurance.

- Supported the gutting of the U.S. Housing and Urban Development’s disparate impact rule – despite pleas from several insurers to leave the rule alone in the aftermath of the murder of Black Americans at the hands of police.

- Pushed NCOIL to adopt a resolution opposing the CASTF White Paper because it suggested that regulators could ask insurers to show a rational relationship between new data sources and insurance outcomes.
How Have the Insurer Trades – Particularly NAMIC and APCIA – Responded to the Insurer CEOs’ Calls? (con’t)

- Opposed state bills to limit the impacts of credit-based insurance scores during a pandemic, citing insurers’ need for “risk-based pricing,” while supporting efforts to permit such deviations when insurers find it convenient – price optimization, consumer lifetime value.

- Pushed NCOIL to adopt a definition of proxy discrimination that would block any efforts to identify and address disparate impact and proxy discrimination and shield insurers from any accountability for their practices.
NCOIL’s “Definition” of Proxy Discrimination Must Be Rejected

At the urging of the P/C Trades, NCOIL recently adopted the following:

For purposes of this Act, as well as for the purpose of any regulatory material adopted by this State, or incorporated by reference into the laws or regulations of this State, or regulatory guidance documents used by any official in or of this State, “Proxy Discrimination” means the intentional substitution of a neutral factor for a factor based on race, color, creed, national origin, or sexual orientation for the purpose of discriminating against a consumer to prevent that consumer from obtaining insurance or obtaining a preferred or more advantageous rate due to that consumer’s race, color, creed, national origin, or sexual orientation.

At best, this action represents a profound misunderstanding of how systemic racism affects insurance. At worst, it is a conscious act of stopping insurance regulators and states from even attempting to address racial justice. The language memorializes insurer practices that indirectly discriminate on the basis of race, discourages insurers from examining such racial impact and restricts current regulatory efforts.
Addressing Systemic Racism in Insurance –
A Comprehensive Approach Needed

CEJ applauds the efforts of the NAIC, individual states, insurance trades and individual insurers to examine, measure and improve racial diversity in leadership and throughout their organizations. While improving diversity is an important goal and strategy to address systemic racism in insurance, it is not nearly sufficient to address the structures that have caused insurer practices to reflect and perpetuate historic discrimination.

Concrete steps within a comprehensive framework are needed:

1. Explicit recognition of disparate impact and/or proxy discrimination against protected classes as unfair discrimination in insurance.

2. Develop guidance to require insurers to test for and minimize disparate impact in all aspects of their consumer-facing operations – marketing, underwriting, pricing, claims settlement, antifraud, payment plan eligibility, investments.
3 Develop guidance for regulators and insurers for acceptable methods of testing and reporting results of testing for disparate impact to regulators and the public.

4 Develop a data reporting framework to permit meaningful and timely analysis of availability and affordability of insurance, generally, and in communities of color.

5 Add a charge to all committees, task forces and working groups to examine their subject area for insurer and regulatory practices that may reflect and perpetuate historic racial discrimination.

6 Add a charge to relevant committees to identify public or regulatory policies that unfairly discriminate on the basis of race, including identification of low-value products targeted at communities of color.
7 Commit to significantly more consumer participation, generally, and consumers from communities of color, specifically, in NAIC proceedings and events. Efforts to improve consumer stakeholder participation should be measured with a concrete target of equal time with industry stakeholders.

8 Direct committees, task forces and working groups to be guided by and to implement the NAIC’s Principles on Artificial Intelligence. The massive increase in insurers’ use of big data and AI has increased the potential for proxy discrimination and disparate impact. Efforts to address systemic racism in insurance are inseparable from more effective oversight of insurers’ use of big data and AI.

9 Update model laws regarding advisory organization. Any effort to implement the NAIC’s AI principles and the address systemic racism in insurance must modernize and expand the reach of state advisory organization laws.
Why Test for Disparate Impact and Proxy Discrimination in All Aspects of Insurers’ Operations?

Among the various parts of the insurance life-cycle – marketing, underwriting, pricing, claims settlement, antifraud – new data sources and complex algorithms for pricing currently get the most attention from regulators because in most states most insurers file personal lines rates. Data and algorithms used for marketing, in contrast, get little or no attention. Yet, it is the marketing function – and the new data sources and algorithms used in micro-targeting consumers – that has become the true gatekeeper for access to insurance.

Consider the following quotes from 2005 to present. In 2005, in a meeting with investment analysts, the CEO of a major publicly-traded insurer was effusive about the benefits of the then relatively new use of consumer credit information – referred to as tiered pricing.
Tiered pricing helps us attract higher lifetime value customers who buy more products and stay with us for a longer period of time. That’s Nirvana for an insurance company.

This year, we’ve expanded from 7 basic price levels to 384 potential price levels in our auto business.

Tiered pricing has several very good, very positive effects on our business. It enables us to attract really high quality customers to our book of business.

The key, of course, is if 23% or 20% of the American public shops, some will shop every six months in order to save a buck on a six-month auto policy. **That’s not exactly the kind of customer that we want.** So, the key is to use our drawing mechanisms and our tiered pricing to find out of that 20% or 23%, to find those that are unhappy with their current carrier, are likely to stay with us longer, likely to buy multiple products and that’s where tiered pricing and a good advertising campaign comes in.
Now fast forward to 2017, when the new CEO of that insurer told investment analysts:

The insurer’s “universal consumer view” keeps track of information on 125 million households, or 300 million-plus people, Wilson said.

“When you call now they’ll know you and know you in some ways that they will surprise you, and give them the ability to provide more value added, so we call it the trusted adviser initiative”
And just recently, the telematics subsidiary of this insurer pitched its ability to identify the most valuable customers in real time:

Attract the most profitable drivers with telematics-based targeting

Traditionally, insurance marketing has relied on demographic and behavioral data to target potential customers. While useful at a high level, these proxies fall short when it comes to considering customer value and retention. Now, you can reach the most profitable customers from the outset using the nation’s first telematics-based marketing platform.

Company intelligently layers driving score onto insurer campaign targeting criteria to purchase the ideal audience based on quartiles of driving risk. [The] Scored user receives a targeted offer via awareness and performance channels.
Not to be outdone, another telematics data vendor announced a partnership with an auto manufacturer

Insurers can harness the power of connected Hyundai vehicles as a new marketing channel to support the profitable growth of their behavior- or mileage-based programs. Discount Alert allows insurers to deploy personalized marketing offers directly to drivers through Hyundai’s online owner portal and contains robust tools to anonymously segment ideal risk targets—ensuring your offers are only sent to qualified leads.

All of this begs the questions, what about consumers and businesses who don’t have the wealth to provide the value sought by insurers? How do these strategies line up with public policies against discrimination on the basis of race and promoting widespread availability of insurance?
Comments from the Center for Economic Justice

To the NAIC Committee on Race and Insurance

March 23, 2021

CEJ writes to supplement our prior comments to the Committee of November 10, 2020 and December 16, 2020.

Our comments today focus on the following:

1. Specific descriptions and definitions of unfair discrimination on the basis of race – disparate treatment, disparate impact and proxy discrimination – and the legislative and regulatory response to each type of unfair discrimination.

2. Rejection of the recent NCOIL action to define proxy discrimination only as intentional use of a proxy for a prohibited factor with the intent to discriminate on the basis of the prohibited factor.

3. The need for concrete actions to address the legislative and regulatory policies that permit structural racism to unfairly impact insurance consumers of color.

Unfair Insurance Discrimination on the Basis of Race

CEJ suggests that there are three types of unfair discrimination on the basis of race. The first is intentional discrimination on the basis of race – disparate treatment. While many states prohibit such explicit discrimination, such prohibitions are not universal across all states and all lines of insurance.¹

**Recommended NAIC Action:** Catalog state laws regarding unfair discrimination on the basis of race and other prohibited classes and encourage uniform application to all insurers and all lines of business and all aspects of insurers’ operations – marketing, sales, underwriting, pricing, claims settlement and anti-fraud.

¹ See Avraham, Logue and Schwrcz, “Understanding Insurance Anti-Discrimination Laws.” The authors find “contrary to the conventional wisdom, state insurance antidiscrimination laws vary a great deal: in substance and in the intensity of regulation, across lines of insurance, across policyholder characteristics, and across states.”

The second and third types of unfair insurance discrimination on the basis of race relate to the impacts of structural racism on insurers’ algorithms, products and processes – disparate impact and proxy discrimination.

For purposes of the NAIC’s efforts to address structural racism in insurance, CEJ identifies disparate impact at disproportionate outcomes tied to historic discrimination and embedded in insurance outcomes. One example is the disproportionate presence of certain health problems or shorter life expectancies in communities of color. Because the impacts of historic discrimination are embedded in insurance outcomes, it is a policy decision – and not a technical issue – to protect the groups experiencing the disproportionately poor insurance outcomes. As a policy issue, policymakers have addressed these outcomes prohibiting discrimination on the basis of certain facially-neutral factors in underwriting and pricing. So, regardless of actuarial indications, insurers cannot discriminate on the basis of race in health and life insurance.

For purposes of the NAIC’s efforts to address structural racism in insurance, CEJ identifies proxy discrimination as disproportionate outcomes tied to the use of proxies for the prohibited characteristic and not to the outcomes. We’ve previously described one such situation when insurers were using age and value of the home as underwriting factors for home insurance – with the result that communities of color were systematically denied home insurance because these communities were characterized by older, lower-value homes – a results directly tied to historic discrimination in housing and lending. When challenged, the insurers discovered that the factors they were using – age and value of the home – were more correlated with race than with insurance outcomes. As a result of the disparate impact challenge, the insurers moved to more relevant risk factors – such as the condition of the home and its systems – with the result that insurance became more available in communities of color as the insurers reduced the correlation between their risk classifications and race.

This second type of disparate impact involves intentional or unintentional unnecessary discrimination on the basis of race. It is unnecessary because the facially-neutral factor that is purportedly associated with the insurance outcome is, in whole or in part, a proxy for the protected class characteristic and predictive of that protective class characteristic. Stated differently, the facially-neutral factor has a spurious correlation to the insurance outcome and is really correlated to the protected class characteristic. Attached is a presentation I will be giving at the Casualty Actuarial Society’s Ratemaking and Product Management Seminar that provides a more technical explanation of these concepts.

It is this second type of disproportionate outcome on the basis of protected class membership that proxy discrimination analysis is intended to identify and minimize. It is this type of unnecessary racial discrimination that has been the concern of insurance regulators.
CEJ Comments to NAIC Committee on Race and Insurance
March 23, 2021
Page 3

**Recommended Actions:** Develop regulatory guidance that defines disparate impact and proxy discrimination in insurance.

For **disparate impact**, the definition should track that promulgated by the U.S. Department of Housing and Urban Development in 2013 and reaffirmed in 2016 (attached). The HUD rule defines “discriminatory effect” (i.e. disparate impact) as

> “discriminatory effect” occurs where a facially neutral practice actually or predictably results in a discriminatory effect on a group of persons protected by the Act (that is, has a disparate impact), or on the community as a whole on the basis of a protected characteristic (perpetuation of segregation). Any facially neutral action, e.g., laws, rules, decisions, standards, policies, practices, or procedures, including those that allow for discretion or the use of subjective criteria, may result in a discriminatory effect actionable under the Fair Housing Act and this rule.

The rule establishes a burden-shifting approach to establish disparate impact liability:

Under § 100.500(c), the charging party or plaintiff first bears the burden of proving its prima facie case: that is, that a practice caused, causes, or predictable will cause a discriminatory effect on a group of persons or a community on the basis of race, color, religion, sex, disability, familial status, or national origin. Once the charging party or the plaintiff has made its prima facie case, the burden of proof shifts to the respondent or defendant to prove that the practice is necessary to achieve one or more substantial, legitimate, nondiscriminatory interests of the respondent or defendant. If the respondent or defendant satisfies its burden, the charging party or plaintiff may still establish liability by proving that these substantial, legitimate, nondiscriminatory interests could be served by another practice that has a less discriminatory effect.

For **proxy discrimination**, CEJ suggests the following definition:

Proxy discrimination is the use of a non-prohibited factor that, due in whole or in part to a significant correlation with a prohibited class characteristic, causes unnecessary, disproportionate outcomes on the basis of prohibited class membership.

Coupled with this definition should be the regulatory guidance for insurers to test for and minimize proxy discrimination in all aspects of their consumer-facing operations – marketing, underwriting, pricing, claims settlement, antifraud, payment plan eligibility, investments – and to report the results of such testing to insurance regulators and the public.

In addition, the Committee on Race should develop regulatory guidance for insurers and regulators regarding acceptable methods of testing, sources of proxies for racial characteristics and methods of reporting results.
In prior comments and presentations, CEJ has explained the basic concept of proxy discrimination – where a facially-neutral factor is actually predicting race (or other prohibited class characteristic) instead of the insurance outcome. The general methodology to test for proxy discrimination is to use a multi-variate analysis to remove the correlation between race and other predictive factors.

A multi-variate analysis simply means analyzing multiple predictive variables simultaneously. By analyzing the predictive variable simultaneously, the correlation among the predictive variables is removed and the unique contribution of any particular predictive variable to explaining the outcome is better isolated. Using this general approach, we include a predictive variable for race in our multi-variate analysis, like so:

\[ b_0 + b_1X_1 + b_2X_2 + b_3X_3 + r_4R_1 + e = y \]

\( X_1, X_2 + X_3 \) are the predictive variables trying to predict \( y \). The coefficients \( b_1, b_2 \) and \( b_3 \) describe each of the predictive variable contribution to explaining \( y \). Say that \( X_1, X_2 + X_3 \) are age, gender and credit score and we are trying to predict \( y \) – likelihood of an auto claim.

Let’s assume that all three \( X \)s are statistically significant predictors of the likelihood of a claim and the \( b \) values are how much each \( X \) contributes to the explanation of claim. The \( b \) values can be tested for statistical significance – how reliable are these estimates of the contribution of each \( X \)?

When we add a predictive variable for race – \( R_1 \) – as a control variable in the model development, the correlation of the \( X \)s to race is statistically removed and the new \( b \) values are now the contribution of the \( X \)s, independent of the predictive variables correlation to race.

What might the results of such an analysis and resulting regulatory response be? The table below describes outcomes, interpretation of those outcomes and the indicated action.
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Interpretation</th>
<th>Indicated Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>R is not statistically significant and there is little change to b1, b2 and b3.</td>
<td>There is little correlation between X1, X2 and X3 and race, little or no disparate impact or proxy discrimination</td>
<td>None, utilize the model.</td>
</tr>
<tr>
<td>R is statistically significant and b1 has lost its statistical significance</td>
<td>X1 was largely a proxy for race and the original predictive value of X1 was spurious. This is an example of proxy discrimination</td>
<td>Remove X1 from the marketing, pricing, claims settlement or anti-fraud model.</td>
</tr>
<tr>
<td>R is statistically significant, but b1, b2 and b3 remain statistically significant with different values from the original.</td>
<td>X1, X2 and X3 are correlated to race, but also predictive of the outcome, even after removing the variables’ correlation to race. This is an example of some proxy discrimination and some disparate impact.</td>
<td>Depending on the significance of the racial impact, utilize the model with the revised predictive variable coefficients, consider prohibiting a variable on the basis of equity or both.</td>
</tr>
<tr>
<td>R is statistically significant and has a large impact on the outcome, but b1, b2 and b3 remain largely unchanged and statistically significant</td>
<td>This is an example of disparate impact.</td>
<td>Are X1, X2 or X3 essential for the insurer’s business purposes? Are there less discriminatory approaches available? Would eliminating a predictive variable significantly reduce the disparate impact but not materially affect the efficiency or productiveness of the model?</td>
</tr>
</tbody>
</table>
Reject NCOIL’s Recent Action to Define Proxy Discrimination

NCOIL has recently adopted a change to its property/casualty modernization model act by defining and prohibiting proxy discrimination. Here is the adopted definition of proxy discrimination, with key parts highlighted, is:

For purposes of this Act, as well as for the purpose of any regulatory material adopted by this State, or incorporated by reference into the laws or regulations of this State, or regulatory guidance documents used by any official in or of this State, “Proxy Discrimination” means the intentional substitution of a neutral factor for a factor based on race, color, creed, national origin, or sexual orientation for the purpose of discriminating against a consumer to prevent that consumer from obtaining insurance or obtaining a preferred or more advantageous rate due to that consumer’s race, color, creed, national origin, or sexual orientation.

This action by NCOIL, at the urging of the property/casualty trade associations, reflects a profound misunderstanding of how systemic racism affects insurance. By defining proxy discrimination only as intentional use of a proxy characteristic for a protected class characteristic, the revisions, if adopted, would memorialize insurer practices that discriminate indirectly on the basis of race, discourage insurers from examining the racial impact of their practices and would restrict current regulatory efforts to address such unfair discrimination.

Further, by the industry’s own admission, the proposed revision do not enhance current regulatory authority. Rather, as industry is surely aware, the proposed revisions would hand cuff regulatory efforts to address proxy discrimination. The proposed revisions reflect such a misunderstanding of proxy discrimination and disparate impact that NCOIL will be inviting federal civil rights legislation aimed at insurance if the proposed revisions are adopted.

This definition misunderstands how systemic racism impacts society in general and insurance operations, specifically. Systemic racism involves institutional and personal biases that reflect and perpetuate historic discrimination. As Justice Kennedy wrote in the Inclusive Communities decision upholding disparate impact as unfair discrimination under the Fair Housing Act (which covers home insurance):

Recognition of disparate-impact claims is also consistent with the central purpose of the FHA, which, like Title VII and the ADEA, was enacted to eradicate discriminatory practices within a sector of the Nation’s economy.

Recognition of disparate-impact liability under the FHA plays an important role in uncovering discriminatory intent: it permits plaintiffs to counteract unconscious prejudices and disguised animus that escape easy classification as disparate treatment.
The proposed revisions would undermine the effort to address systemic racism in two ways. First, by defining proxy discrimination only as intentional use of a proxy for a prohibited class characteristic, the revisions set an impossible bar. Even if an insurer were using a perfect proxy for race, under the proposed NCOIL revisions, the regulator could take no action without proving an intent to discriminate and substitute on the basis of race. Were this requirement in effect, state regulators could never have taken action in the past on race-based pricing in life insurance.

Second, the requirement to prove intent reflects a profound misunderstanding of how systemic racism is reflected in and perpetuated by unconscious institutional, cultural and personal biases. The purpose of a proxy discrimination standard and methodology to address unnecessary disproportionate outcomes on the basis of race and other protected classes is to reveal the unnecessary and unintentional bias through rigorous and objective analysis. The proposed revisions move in the opposite direction by focusing on intent instead of on outcomes.

**Concrete and Measurable Actions to Address Systemic Racism in Insurance**

CEJ applauds the efforts of the NAIC, individual states, insurance trades and individual insurers to examine, measure and improve racial diversity in leadership and throughout their organizations. While improving diversity is an important goal and strategy to address systemic racism in insurance, it is not nearly sufficient to address the structures that have caused insurer practices to reflect and perpetuate historic discrimination.

Our comment letter of December 16, 2020 provides more detail, but we urge the following actions by the NAIC.

1. Explicit recognition of disparate impact and proxy discrimination against protected classes as unfair discrimination in insurance.

2. Develop guidance to require insurers to test for and minimize disparate impact in all aspects of their consumer-facing operations – marketing, underwriting, pricing, claims settlement, antifraud, payment plan eligibility, investments.

3. Develop guidance for regulators and insurers for acceptable methods of testing and reporting results of testing for disparate impact to regulators and the public.

4. Develop a data reporting framework to permit meaningful and timely analysis of availability and affordability of insurance, generally, and in communities of color, specifically – sales data showing products sold with price by specific type by granular geography area.
Add a charge to all committees, task forces and working groups to examine their subject area for insurer and regulatory practices that may reflect and perpetuate historic racial discrimination. Adding such charges is vitally important because many working groups have refused such analysis, arguing that other groups at the NAIC are looking at these issues. While there is certainly a role for the Committee on Race to provide broad guidance, it is essential that the subject matter experts – whether financial, producer licensing, antifraud, market regulation or lettered committees – examine these issues based on their in-depth knowledge of the particular subject area.

Add a charge to relevant committees – particularly the Life A, Health B, Property Casualty C and Market Regulation D Committees – to identify public or regulatory policies that unfairly discriminate on the basis of race, including identification of low-value products targeted at communities of color.

Commit to significantly more consumer participation, generally, and consumers from communities of color, specifically, in NAIC proceedings and events. Even following the NAIC’s stated commitment to address systemic racism in insurance last year, several NAIC events had minimal or no consumer participation. As we have noted in prior correspondence, it is the relative absence of consumer stakeholders from communities of color that has led to broad adoption of insurer trade association priorities that have, at best, ignored, systemic racism in insurance and, at worst, exacerbated the problem. Efforts to improve consumer stakeholder participation should be measured with a concrete target of equal time with industry stakeholders.

Direct committees, task forces and working groups to be guided by and to implement the NAIC’s Principles on Artificial Intelligence. The massive increase in insurers’ use of big data and AI has increased the potential for proxy discrimination and disparate impact. Efforts to address systemic racism in insurance are inseparable from more effective oversight of insurers’ use of big data and AI.

Update model laws regarding advisory organization. The purpose of advisory organization provisions in NAIC model laws and individual state laws is to provide necessary regulatory oversight of collaborative efforts by industry within the limited anti-trust carve-out of the McCarran Ferguson Act. It is only with oversight of advisory organizations that insurers are able to utilize an advisory organization for industry standard policy forms or rating assistance, like loss cost filings for overall loss trends and risk classification relativities. Yet, today, while a few organizations that have been licensed as advisory organizations for decades continue to maintain such license and, consequently, remain subject to regulatory oversight, many more organizations are engaged in the same type of collaborative or collusive activities but remain unlicensed as advisory organizations. Any effort to implement the NAIC’s AI principles and the address systemic racism in insurance must modernize and expand the reach of state advisory organization laws.
Comments of the Center for Economic Justice to the

NAIC Committee on Race and Insurance

December 16, 2020

CEJ submits these comments to the Committee on Race and Insurance to provide a comprehensive set of recommendations addressing all of the work streams. Our recommendations are most detailed for the line of business and regulatory diversity work streams. We have limited comments on the insurance industry diversity work stream.

As mentioned in earlier comments and presentations, it is relevant and necessary to determine why, despite CEJ or other consumer and civil rights advocates raising issues of racial discrimination in insurance for decades, it took the murder of George Floyd for the NAIC and industry to acknowledge the problem and commit to actions to address systemic racism in insurance.

We offered our analysis of the structural impediments to regulatory action to address systemic racism in insurance in the past in our August 14, 2020 presentation, attached:

- Lack of Minority Voices and Experience in Insurer and Regulator Leadership
- Imbalance Between Consumer and Insurer/Producer Access to Critical Regulatory and Legislative Processes
- Trade Associations Fighting to Protect Practices that Reflect and Perpetuate Systemic Racism in Insurance
- Regulatory Authorities and Infrastructure Failing to Keep Up With Seismic Changes in Insurer Practices.

We all know that the lack of diversity among insurers and regulators is a problem. But, what has led to this lack of minority participation? Improving diversity is a strategy and not the goal. It is a strategy to cause insurers and regulators to better consider the impacts of their practices on communities of color by having people making decisions better reflecting the people who are affected by those decisions. The goal is racial justice and improved diversity is one part of the strategy to attain that goal.
Our recommendations are informed by our 30 years of working on racial and economic justice in insurance at the NAIC, in the states and before Congress and the lessons we’ve learned about what’s necessary to create the changes to lead to racial justice.

Our recommendations are presented as follows:

- Recommendations Common to All Line of Business Work Streams
  - Recommendations for Actions by the Committee on Race and Insurance
  - Recommendations for Actions by Other NAIC Committees, Task Forces and Working Groups
- Recommendations for Improving Regulatory Diversity
- Recommendations for Improving Insurer and Producer Diversity

**Recommendations Common to All Line of Business Work Streams**

**Recommendations for Committee on Race and Insurance**

1. Explicit recognition of disparate impact / proxy discrimination against protected classes as unfair discrimination in insurance

2. Develop guidance to require insurers to test for and minimize disparate impact in all aspects of their consumer-facing operations – marketing, underwriting, pricing, claims settlement, antifraud, payment plan eligibility, investments

3. Develop guidance for regulators and insurers for acceptable methods of testing and reporting results of testing for disparate impact to regulators and the public

4. Develop a data reporting framework to permit meaningful and timely analysis of availability and affordability of insurance, generally, and in communities of color, specifically – sales data showing products sold with price by specific type by granular geography area.

**Discussion**

1. Explicit recognition of disparate impact / proxy discrimination against protected classes as unfair discrimination in insurance

   Regulators have made clear in a variety of discussions that you believe you have authority to stop proxy discrimination against protected classes or disparate impact as unfair discrimination in insurance. You memorialized this in the principles for Artificial Intelligence which included a requirement for insurers to pro-actively avoid proxy discrimination against protected classes.
Yet, industry has fought and continues to oppose the proposition that unfair discrimination on the basis of race means anything other than intentional discrimination. Industry has reiterated this position several times including most recently at the NCOIL annual conference in which they argued against and opposed any regulatory authority or insurer responsibility to address unintentional, unneeded proxy discrimination on the basis of race.

Clearly, any serious effort to address systemic racism in insurance must address practices that intentionally or unintentionally, reflect and perpetuate historic discrimination against protected classes. If the NAIC is to make any progress, it must avoid endless debates with industry about legislative intent or regulatory authority and start with the proposition that, whatever one thinks the current legislative intent or regulatory authority may be, the NAIC starts from the foundational premise that disparate impact is unfair discrimination in insurance. If changes are needed in legislative intent or regulatory authority, the NAIC will develop the model guidance necessary, but there should not be debate about the principle that is the foundation of racial justice.

2. Develop guidance to require insurers to test for and minimize disparate impact in all aspects of their consumer-facing operations—marketing, underwriting, pricing, claims settlement, antifraud, payment plan eligibility, investments

Simply stated, it should be part of the DNA of insurers to test all their practices, operations and algorithms for disparate impact and take steps to minimize that impact within the risk-based framework of insurance. The burden must be on insurers to employ practices that do not unnecessarily and unintentionally reflect and perpetuate systemic racism. It is unreasonable to place the burden on consumers or regulators to identify such practices and then challenge insurers, particularly when the vast majority of the practices are opaque to regulators or consumers and incorporated into black-box big data algorithms.

Lenders have had such a responsibility for decades and testing for and minimizing disparate impact is simply part of the development of lender underwriting, pricing and other practices.¹

It is also essential that insurers test for racial inequities in all aspects of their consumer-facing operations. It is far from sufficient to examine only underwriting and pricing. In an era of big data micro-targeting, insurers, like other businesses, have the ability to micro-target particular product marketing to individuals with the result that the underwriting process is effectively moved to the marketing program.

Slides 25 to 27 of the attached CEJ presentation to NCOIL cite insurer CEO statements to investment analysts in which the CEO explain not just their intent to attract “high-value” customers and repel low-value customers—labels which reflect racial bias—but the ability to use marketing tools and big data to micro-target those high-value customers. It is specifically the big data tools like price optimization, customer lifetime value and propensity for fraud that are use and which rely on data and algorithms that reflect and perpetuate systemic discrimination. The

¹ See for example, chapter 10 of Credit Scoring for Risk Managers: The Handbook for Lenders.
amount of personal consumer information available for micro-targeting is incomprehensibly large – just look at the websites of data brokers or vendors specializing in assisting insurers like Carpe Data or Journaya.

We’ve repeatedly raised the concern about claim settlement and antifraud algorithms that rely on biased data and biased modelers. In the case of antifraud, biased algorithms become self-fulfilling because an insurer will not find fraud if the claim isn’t investigated. So bias in deciding which claims are suspicious will lead to bias in the claims labeled as fraudulent.

Insurers should also examine their investments and investment practices for climate and environmental justice. Numerous studies have shown that historical racism in housing has led to more severe impacts of climate change on communities of color as well as more severe impacts of the pandemic. Further, racial justice must consider and incorporate environmental and economic justice. Insurers should be examining their investments and investment practices to ensure they are not, for example, supporting predatory lenders or racist housing and environmental policies.

It is essential that the approach taken to address racism in insurance be holistic and comprehensive. Attempting to prohibit one offensive rating factor or data source or algorithm is a fool’s errand. The same racial bias from that one prohibited factor will likely be replicated by another new data source or algorithm. Further, the goal should not be to eliminate data sources for insurers, but require the use of any data source in a manner that eliminates or minimizes the disparate impact.

The action needed here is for the Committee on Race and Insurance to develop the guidance for the requirement that insurers test for and minimize disparate impact in their practices. This will be universal guidance – and the guidance sought by many of the NAIC working groups – like the Casualty Actuarial and Statistical Task Force and the Anti-Fraud Task Force – who have punted on addressing issues of racial equity in algorithms.

3. Develop guidance for regulators and insurers for acceptable methods of testing and reporting results of testing for disparate impact to regulators and the public

Once the requirement for insurers to test for and minimize disparate impact is established, the next step is for the Committee on Race and Insurance to develop the guidance for how insurers should test, minimize and report the results of such disparate impact testing. This guidance should include data sources for protected class characteristics if the insurers does not collect those data, acceptable and unacceptable methods of testing, safe harbors for insurers who test for and minimize disparate impact and how and how often to test and report results to regulators and the public.
It is important to note that insurance regulators do not have to reinvent the wheel here. There is a rich history of disparate impact testing methodologies not just from here in the U.S. related to federal employment, lending and housing laws – and applications of disparate impact analysis to insurance under the Fair Housing Act – but experience from other nations about how to address disparate impact in insurance.

4. Develop a data reporting framework to permit meaningful and timely analysis of availability and affordability of insurance, generally, and in communities of color, specifically – sales data showing products sold with price by specific type by granular geography area.

The Committee on Race and Insurance must address another key structural impediment to racial justice in insurance – the absence of routine data reporting by insurers of granular consumer market outcomes sufficient to analyze the impact of insurer marketing, sales, claims and antifraud practices on communities of color.

The contrast between the lack of market outcome data in insurance and other financial services is stark. While public and private sources have reported the impact of the pandemic and federal relief (e.g. CARES Act) on all types of borrowers on a weekly and monthly basis – including changes in delinquencies, late payments, use of forbearance and much more – insurance regulators have had no information on consumers’ use of premium relief or real-time changes in claims during the pandemic.

More important, insurers have steadfastly opposed the publication of data by individual insurers by ZIP Code or Census Block that permits regulators, academics, consumer and civil rights groups from analyzing racial disparities in insurance. Regulators must overcome this opposition and develop a market regulation data reporting regime that matches the financial regulation data reporting regime in breadth and intensity.

**Taken together, these four common-to-all-work stream actions should be memorialized in two charges to the Committee on Race and Insurance – one regarding disparate impact and one regarding data collection.**

**Recommendation for Specific to Lines of Business**

In addition to certain racial justice actions that should be centralized at the Committee on Race and Insurance, there are also activities that should be assigned to other NAIC committees, task force and working groups. We mentioned above that some NAIC working groups have specifically rejected requests to examine racial bias in insurer practices that fall under that working group activity. For example, the CASTF white paper on predictive modeling explicitly rejected addressing racial bias in regulatory review of algorithms. The Antifraud Task Force explicitly rejected including a requirement for insurers to test for racial bias in antifraud practices and algorithms in the recent update the antifraud policy guideline. Both groups based their decision on the claim that other groups at the NAIC were working on the issue.
While the development the guidance on how to test for, minimize and reporting the findings of disparate impact analysis should be centralized at the Committee on Race and Insurance, there are several actions that individual committees, task forces and working groups can and should take to help achieve racial justice in insurance.

1. Add a charge to identify potential **insurer practices** that disadvantage or disproportionately discriminate against communities of color.

   Each committee, task force and working group should receive a charge for 2021 to identify insurer practices that may disadvantage or disproportionately discriminate against communities of color. Such a charge is vital for each of the subject matter groups to have ownership of the issue and to educate themselves about race and insurance. The outcome from this charge – a list of practices that insurers should prioritize for disparate impact testing – will complement the work of the Committee on Race and Insurance.

2. Add a charge examine **public policies** that disadvantage or disproportionately discrimination against communities of color.

   This second charge to all committees, task forces and working groups is directed at public policies that unfairly harm communities of color. This charge focuses more on laws and regulatory guidance, as opposed to practices under the discretion of insurers. The outcome from this charge – a list of public policies, laws, regulations and regulatory guidance that unfairly discriminate against communities of color – will also complement the work of the Committee on Race and Insurance. To illustrate, we list some public policies related to private passenger auto that disproportionately and unfairly impact communities of color.

   a. Property Casualty / PPA
      i. Pay to Play Laws Punishing Uninsured Drivers
      ii. Territorial Rating for Uninsured Motorists
      iii. High Minimum Limits
      iv. Criminal Penalties / Debtors Prison for Uninsured Motorists
      v. Oversight of Advisory Organizations / Data Brokers

3. Add a charge to **identify low-value products targeted to communities of color and new high-value products opportunities that better meet the needs of communities of color.**

   A third charge to all committees, task forces and working groups is directed at identifying current products that, because of their low-value, strip consumers of assets instead of protecting those assets. In our experience, these low-value products are disproportionately marketed to and sold in and to communities of color. In addition, some lines of business simply have no products designed for the needs of communities of color and there are opportunities to identify the unique needs of these communities and then develop high-value products targeted to meet those needs. As discussed below, this charge is also relevant for addressing diversity in insurers and producers.
Recommendations for Regulatory Diversity

We have a series of recommendations to improve diversity within the regulatory community. As set out in our earlier comments and presentations to the Committee, the lack of diversity among the regulatory community and the regulatory decisions which codify disparate impact are a result of a lack of consumer stakeholder participation, generally, and an even greater absence of stakeholders from communities of color, specifically. Our recommendations are:

1. Develop guidance for establishing a public agency dedicated to representing consumer before the Department of Insurance and the Legislature – a Bureau of the Insurance Consumer Advocate.

2. Measure consumer participation, generally, and minority participation, specifically in NAIC meetings and conferences and events.

3. Allocate speaking time, when there are time constraints, based on industry / consumer, not based on number of speakers.

4. Increase funding for NAIC consumer participation to permit consumer reps to retain experts for priority projects.

Discussion

1. Develop guidance for establishing a public agency dedicated to representing consumer before the Department of Insurance and the Legislature – a Bureau of the Insurance Consumer Advocate.

There is a great need to establish institutions to advocate on behalf of consumers before insurance departments and state legislatures to level the playing field versus the hundreds of millions of dollars of policyholder-supplied funds spent by insurers and trade associations to press their views.

The establishment of a Bureau of Insurance Consumer Advocate in each state would have an impact far beyond the advocacy for consumers performed by that agency. These BICAs create opportunities for employment, including minority employment, in insurance other than working for insurers or regulators. And they create employment opportunities outside of industry for regulators who want to leave the insurance department. BICAs are a strategy to increase diversity in insurance as well as addressing a core barrier to ending systemic racism in insurance.
2. Measure consumer participation, generally, and minority participation, specifically in NAIC meetings and conferences and events.

3. Allocate speaking time, when there are time constraints, based on industry / consumer, not based on number of speakers

    If you can’t measure it, you can’t fix it. Speaking about diversity in abstract terms cannot lead to assessment of failure or success of the strategies to improve diversity. Further, a requirement to measure diversity in NAIC events will raise awareness of the need to improve diversity.

    The need for such improvement is huge. We’ve pointed out that the CIPR events at the NAIC Summit not only failed to include any minority voices, but included one overtly racist presentation. We’ve pointed out that this year’s Insurance Regulatory Examiners’ Society Career Development Seminar failed to include any minority or consumer presenters. And these results occurred after the NAIC declared its commitment to racial justice. It gets worse. At the recent Fall National Meeting, the CIPR event on pandemic insurance featured eight white men. No members of the communities of color most impacted by the lack of pandemic insurance. No small businesses from communities of color. No consumer stakeholders who have been active in these debates from day 1.

    The two actions will help ensure that NAIC event planners, committees, task forces and working groups better understand the importance of consumer stakeholder participation, generally, and minority participation, specifically.

    As someone who is often the only consumer stakeholder among many industry stakeholders in NAIC meetings, I’m keenly aware of situations in which a half dozen industry trades each have the same amount of time as me – to repeat and agree with each other trade’s comments. To be clear, this is not always the case, but the larger point is that, when speakers’ time is limited, the allocation of that time should be based on the major positons/views and not on the sheer number of speakers.

4. Increase funding for NAIC consumer participation to permit consumer reps to retain experts for priority projects and engage with stakeholders from communities of color impacted by NAIC deliberations.

    As someone who has been involved in the NAIC Consumer Participation program from its beginning 30 years ago, I’m grateful for the NAIC’s commitment to consumer participation. The NAIC program stands in contrast to the absence of such a formal consumer participation program in most states and other organizations, like NCOIL.

    The NAIC consumer participation budget is about 0.1% of the total NAIC budget. It covers reimbursement of travel expenses for funded consumer representatives to attend NAIC national and interim meetings and some IAIS events. It also covers registration fees, publication costs and conference call costs for funded and unfunded consumer representatives. No consumer
representative is paid for their time out of NAIC funds. Most funded and unfunded consumer representatives volunteer their time – beyond their regulator work commitments – to advocate for consumers at the NAIC.

We are not asking for NAIC consumer representatives to be compensated for our time at NAIC events. Rather, we’re asking for additional funding to leverage our individual contributions to retain subject-matter experts or consultants or to fund participation from key stakeholders from communities of color to assist the consumer representatives on key issues. This assistance is particularly important in areas like consumer testing of information and disclosures and analyzing actuarial, reserving, accounting, investment or capital-related proposals.

The NAIC consumer representatives took responsibility for the lack of minority voices among our group in 2020 by recruiting heavily for applicants representing communities of color. We were successful in encouraging many new, exceptionally-qualified applicants of color and hope they will be accepted as NAIC consumer representatives. But, we want these new consumer representatives – if accepted by the Consumer Board of Trustees – to feel their time is well spent and to continue to participate for years to come while helping recruit new consumer stakeholders of color. For that to happen, the Consumer Participation program must be strengthened and one way is to increase NAIC funding for the consumer reps to use to retain experts and consultants and reach out to communities and stakeholders impacted by NAIC discussions.

**Recommendations for Insurer Diversity**

1. Identify products providing low-value to communities of color and develop new high-value products that better meet the needs of communities of color

We offer this action to improve insurer diversity based on the belief that someone will want to work for companies who provide products and services that that person and that person’s community values and likes. Why would members of community color want to work for an industry that the community perceives as ripping them off? We suggest that if communities of color value the products sold by insurers, members of those communities are more likely to seek out work with those insurers.

This recommendation is essentially the opposite of suggestions to improve financial or other education in communities of color. In our view, the improve-education argument blames the victim. Our approach suggests that people are not uneducated, but want to work for companies providing products that they and their community like and value.

2. Examine impact of criminal history in producer licensing qualifications

We raise this specific issue because of documented disparity and racial discrimination in policing and criminal complaints against members of communities of color.
April 9, 2021

Dear Committee Members:

The undersigned civil rights, consumer, and community organizations urge the National Association of Insurance Commissioners (NAIC) Committee on Race and Insurance to take urgent action to address the racially discriminatory use of credit-based insurance scores for underwriting and pricing auto insurance and other personal lines of coverage, such as renters’ and homeowners’ insurance. Consistent with NAIC’s mission to facilitate the fair and equitable treatment of insurance consumers, we call on the committee to issue a recommendation that credit information no longer be used to determine eligibility for, or the cost of, auto or home insurance.

Drawing on premium data from Quadrant Information Services, LLC, the Consumer Federation of America finds that drivers with poor credit can be charged as much as 283 percent more for auto insurance than those with excellent credit—regardless of their driving record. This translates into higher premium charges every month for a product that drivers are required by state law to purchase. Our greatest concern is that the use of credit-based insurance scores for auto insurance pricing perpetuates discrimination because credit data reflects racial disparities.

It’s true that credit data—including credit-based insurance scores—never formally takes race into account. Yet these metrics are not race-neutral, because they draw on data about personal borrowing and payment history that is shaped by generations of discriminatory public policies and corporate practices.

From the American economy’s earliest roots in chattel slavery that treated Black people as property to more recent policies like redlining, Black and brown families have been systematically excluded from wealth-building opportunities that benefited white families. Exclusion produced vast wealth disparities that persist to this day: according to an analysis by researchers at the Federal Reserve, for every dollar in wealth held by the median white household in 2019, the median Black household had less than 13 cents, and the median Latinx household had just 19 cents. This inequality is now being exacerbated by the uneven economic effects of the pandemic, including higher unemployment rates for Black and Latinx workers. With less wealth to draw on, the median Black and Latinx households facing economic hardship exhaust their limited resources more quickly than the median white household and are more likely to fall behind on bills and go into debt. And because consumers with poor credit are more likely to be denied loans, charged higher interest rates, and charged more for products like auto insurance, the cycle of disadvantage reinforces itself. One result is that Black and brown consumers disproportionately appear in the data as worse credit risks.

When auto insurers use credit information as a factor in determining prices, they reinforce historic discrimination. For example, a 2017 analysis by ProPublica found that major insurers in California, Illinois, Missouri, and Texas charge drivers living in predominantly Black and Latinx neighborhoods as much as 30 percent more than drivers living in other areas with similar accident costs. Drivers living in predominantly Black and Latinx zip codes in New Jersey pay 139 percent of the statewide premium average of $1,459.69 for a 35-year-old driver with a clean driving record and other standardized characteristics, according to data sourced from Quadrant Information Services, LLC and compiled by Consumer Federation of America.
The use of credit-based insurance scores is not the only way that systemic racism impacts insurance underwriting decisions, premiums, claims handling, and fraud investigation, but it is a clear source of bias in the industry. We urge the committee to recommend to state insurance commissioners and legislatures that credit information no longer be used in auto and home insurance pricing.

Thank you for your efforts, and we look forward to working with the NAIC to build a fairer system.

Sincerely,

Consumer Federation of America
Demos

CAARMA Consumer Advocates Against Reverse Mortgage Abuse
CASH Campaign of Maryland
Center for Economic Integrity
Center for Economic Justice
Citizens Action Coalition of IN
Consumer Action
Consumer Auto
Consumer Federation of California
Consumers for Auto Reliability and Safety
Empire Justice Center
Georgia Watch
GVE Media/Public Relations, LLC
Job Opportunities Task Force
Maryland Consumer Rights Coalition
Maryland Legal Aid
Maryland Legislative Coalition
MD Alliance for Justice Reform
Mountain State Justice, Inc.
National Consumer Law Center (on behalf of its low-income clients)
National Fair Housing Alliance
Public Citizen
Public Good Law Center
Public Justice Center
Robert W. Deutsch Foundation
SC Appleseed Legal Justice Center
Showing Up for Racial Justice Baltimore
Student Borrower Protection Center
Vehicles for Change
World Privacy Forum
1 Consumer Federation of America, forthcoming.
April 9, 2021

David Altmaier, Co-Chair
Dean Cameron, Co-Chair
Special (EX) Committee on Race and Insurance
c/o Kay Noonan, General Counsel – knoonan@naic.org
1100 Walnut St, Suite 1500
Kansas City, MO  64106-2197

Re: Notice of Meeting of Special (EX) Committee on Race and Insurance

Dear Co-Chairs and Committee Members:

On behalf of the National Association of Mutual Insurance Companies (NAMIC), thank you for the opportunity to provide initial comments on the Committee’s new draft charges released on April 7, 2021. Following a productive conversation with the NAIC officers and NAMIC’s board officers and executive leadership, we have anxiously anticipated the opportunity to partner with you on this very important work. Since the inaugural meeting on September 17, 2020, NAMIC has remained committed to constructive dialogue with the NAIC, regulators, and other interested parties on issues at the nexus of race and insurance.

NAMIC continues to have a strong desire to work with the NAIC in this space on behalf of our industry members. Mutual insurance companies are built on the notions of community and inclusivity; the mutual model has a long and proud history of service to minority communities. NAMIC and NAMIC’s members are adamantly opposed to discrimination on the basis of race and unfair discrimination in general. We have a long history of support for legislative and regulatory policies to prevent these practices. We strongly believe that the elimination of racism improves every aspect of our relationships, institutions, and business communities, and that treating all employees and policyholders with dignity and fairness is essential to the continued success of our industry.

It seems imperative to mention that NAMIC finds itself troubled that such opportunity for engagement and partnership has been so limited on such an important and large body of work. We can certainly appreciate the especially challenging operational year we have all had in the wake of COVID-19, however, we are concerned with the lack of transparency in the committee’s operations to-date, which have included dozens of regulator-only meetings involving the development of a substantive work product like the updated proposed charges. We respectfully request that appropriate time and attention is given to ensuring that future meetings are open and stakeholders are provided sufficient opportunity to provide insightful input, as we all work to find solutions that are “right” and “implementable.” Going forward, we strongly encourage the Committee to, at minimum, provide
adequate time to review proposals/exposures, as well as access to forums where these very important proposals are being discussed.

In light of the short time window provided to comment on the draft updated charges for 2021, the following non-exhaustive comments are framed as a series of questions we believe should be publicly considered and addressed before any additional substantive work takes place.

General Questions:

- Is it the Committee’s intention to develop a model law or regulation? If so, is it the NAIC’s intention that such a model would be an accreditation standard?
- Does the Committee intend to develop specific definitions for historically underrepresented and disadvantaged groups?
- How will “workstreams” be treated under the NAIC Open Meetings Policy? Will the open meetings policy be amended to include the term “workstream?”
- Is the Committee or the NAIC willing to make a commitment to risk-based pricing? Such a commitment, in writing or in public statements, could alleviate many industry concerns regarding the direction of some of the conversations around the Committee’s activity.

Charge Specific Questions and Comments:

A. Language is used in the charges regarding practices that “potentially” disadvantage people of color and/or historically underrepresented groups – how will the potential for disadvantage be defined and measured?

B. We appreciate the desire to avoid duplicative work – if issues of race are to be studied by other NAIC working groups and task forces, will instructions be added to their charges? Will stakeholders be provided adequate time to comment on those additional charges?

C. We commend the committee for proposing to continue research and development of recommendations on action steps to improve the level of diversity and inclusion across the industry. We look forward to continued partnership with state regulators interested in supporting these critical talent pipeline efforts.

D. Have State DOI’s requested the NAIC’s assistance regarding DE&I efforts? If so, what form have such requests taken, and were they approved by the corresponding state legislatures?

E. It appears the research envisioned regarding State DOI best practices on DE&I efforts would fit more appropriately within the scope of workstream two, not three. Will this change be made?

F. We would recommend the charge be “whether” unfair discrimination is present and “whether” additional appropriate steps are necessary.
F2. Is the contemplated development of analytical and regulatory tools to assist regulators in determining unfair discrimination going to be completed exclusively by NAIC staff? Will new agreements be put in place for the delegation of authority? Which NAIC staff would be involved, and how would that be determined? Would ongoing monitoring of these analytical and regulatory tools be the responsibility of a standing letter committee? Will industry be provided the opportunity to self-monitor with the same tools and participate in the development of those tools? What will happen if an NAIC standard for unfair discrimination is in conflict with state law?

F2 a-f. The additional study to evaluate the validity of the use of correlation rather than causation seems to suggest that a causation standard for underwriting factors is being contemplated; is this accurate? If so, in what ways does the Committee believe any underwriting factor can be said to “cause” a loss? Similarly, it is unclear what “disparate impact considerations” means – under some interpretations, “disparate impact” can mean a simple outcomes-based approach to analysis that is fundamentally incompatible with risk-based pricing.

G. Given that insurers do not currently collect data about policyholder race, would enhanced data reporting to identify the race of insureds be effective? If mandatory collection of racial information is being contemplated, has the committee considered how such a collection requirement may be at odds with state law in some instances and/or raise privacy concerns? How does the Committee envision handling mixed and multi-racial policyholders, or those policyholders that refuse to identify?

H. Charge H6 indicates that steps need to be taken to mitigate the impact of residual markets, premium financing, and nonstandard markets. Does the committee have specific evidence regarding these markets that interested parties may see? If not, we suggest the approach of first investigating “whether” this is the case.

Thank you for the opportunity to comment on the proposed charges. We look forward to continued discussions with the committee, its members, and NAIC staff on these issues in a transparent and constructive manner.

Sincerely,

Jonathan Bergner
Vice President – Public Policy and Federal Affairs
National Association of Mutual Insurance Companies
jbergner@namic.org
April 9, 2021

The Honorable David Altmaier  
Co-Chair  
National Association of Insurance Commissioners  
Special Committee (EX) on Race in Insurance

The Honorable Dean Cameron  
Co-Chair  
National Association of Insurance Commissioners  
Special Committee (EX) on Race in Insurance

Sent via e-mail to Kay Noonan (knoonan@naic.org)

Dear Commissioner Altmaier and Director Cameron –

On behalf of the National Council of Insurance Legislators (NCOIL), we are responding to the request for comments on the recently distributed charges for the National Association of Insurance Commissioners (NAIC) Special Committee (EX) on Race in Insurance (Committee).

Our comments do not delve into the substance of the charges. Rather, we think it is important to remind the Committee that any work product it produces stemming from the charges must operate under a grant of legislative authority. Further, if legislators choose to act on any of the issues dealt with by the Committee by enacting legislation, such legislation will supersede any of the Committee’s regulatory work product.

We also wish to note that it certainly seems discussions leading to the development of the Committee’s charges were heavily substantive and as such would not appear to fit within any of the NAIC’s stated reasons for holding a closed meeting¹.

¹ The NAIC’s stated reason for closing the March 24th meeting of the Committee to the public was: “This is a regulator only session because the discussion or action contemplated will include: Internal or administrative matters of the NAIC or any NAIC member, including budget, personnel and contractual matters, and including consideration of internal administration of the NAIC, including, but not limited to, by the Internal Administration (EX1) Subcommittee or any subgroup appointed thereunder.”
We are hard pressed to see how substantive discussions, which surely took place in developing the Committee’s charges, would constitute mere “internal or administrative matters.” These problems are compounded by a remarkably short period of time for comments to be submitted on the charges, especially when the interested parties that the NAIC has requested comments from were locked out of the process.

We look forward to discussing these issues with your colleagues next week at the NCOIL Spring Meeting as this topic is included on the agenda for the NCOIL – NAIC Dialogue. Among the questions we would like you to consider for discussion include:

- Why did the NAIC choose to use a “special committee” structure for its handling of these highly sensitive, national, and indeed global issues, when “special committees” are not contemplated anywhere in either NAIC bylaws or the NAIC Policy Statement on Open Meetings?

- Is there any precedent for handling such a high-profile issue in this fashion?

- We also wonder about making a “special committee” with the issues attached to it a “coordinating body.” We can find no definition for “coordinating body” anywhere on the NAIC website or in any NAIC documents; does it exist?

- In light of the special importance of these issues, we do wish to discuss why the NAIC opted to hold so many of the discussions surrounding them in a largely non-public format.

With appreciation for your consideration and kind regards, we are,

Very truly yours,

Representative Matt Lehman (IN)  
NCOIL President

Assemblyman Ken Cooley (CA)  
NCOIL Vice President
INFORMATION SYSTEMS (EX1) TASK FORCE

Information Systems (EX1) Task Force March 24, 2021, Minutes
Date: 3/31/21

Information Systems (EX1) Task Force  
Virtual Meeting (in lieu of meeting at the 2021 Spring National Meeting)  
March 24, 2021

The Information Systems (EX1) Task Force met March 24, 2021. The following Task Force members participated: Ricardo Lara, Chair, represented by David Noronha (CA); Kathleen A. Birrane, Vice Chair, represented by Paula Keen (MD); Lori K. Wing-Heier represented by Chris Murray (AK); Alan McClain represented by Letty Hardee (AR); Michael Conway represented by Peg Brown, Damion Hughes and Rolf Kaumann (CO); Trinidad Navarro represented by Tim Li (DE); Sharon P. Clark represented by Satish Akula (KY); Chlora Lindley- Myers, Cynthia Amann and Jo LeDuc (MO); Barbara D. Richardson represented by Nick Stotic (NV); Judith L. French represented by Tynesia Dorsey (OH); Glen Mulready represented by Andrew Schallhorn (OK); Doug Slape represented by Nancy Clark (TX); and Scott A. White represented by Vicki Ayers and Trish Todd (VA). Also participating were: Rebecca Smid (FL); Linda Scott (KS); Larry Wertel (NY); Scott Kast (PA); Joseph Javier (SC); Sharmila Chalasani and Molly Nollette (WA); and Tom Jefferson (WI).

1. **Adopted its Nov. 20, 2020, Minutes**

Ms. Keen made a motion, seconded by Mr. Li, to adopt the Task Force’s Nov. 20, 2020, minutes (see NAIC Proceedings – Fall 2020, Information Systems (EX1) Task Force). The motion passed unanimously.

2. **Received an Update on the 2021 SERFF Fiscal**

Joy E. Morrison (NAIC) reported that the System for Electronic Rate and Form Filing (SERFF) Modernization team received 12 responses from the request for proposal (RFP) issued last fall. NAIC staff and the SERFF Modernization Oversight Group reviewed the responses, interviewed six vendors, and selected a final vendor. There are three goals of the RFP: 1) determining tools to be used; 2) validating that the tools can do what is needed with use cases; and 3) establishing a roadmap from pilot to production. The vendor selected will be announced after a contract is in place. A fiscal was released in March for public comment to fund the project, which is expected to begin in May.

3. **Received an IT Operational Summary Report**

Scott Morris (NAIC) highlighted several sections included in the Information Technology (IT) Operational Report received by the Task Force members. The report provides updates on technology initiatives at the NAIC, upcoming improvements, impacts to state technology, new offerings from the NAIC, and general updates on the activities of the NAIC technology team.

a. **Product Highlights**

The State Based Systems (SBS) team has completed transitions from the legacy system to the new platform for all states. All transitioned states are out of their warranty period, and work continues to decommission the legacy hardware and database. The SBS team is now focusing on new state implementations. Four states are currently licensed for SBS implementation, with three currently active: Vermont (August 2021), Connecticut (November 2021) and Massachusetts (February 2022). Hawaii is a future implementation.

Other key product highlights include:

- A multiphase project for SERFF Billing Enhancements concluded in January, positioning the NAIC and insurance companies to move from a billing model using prepaid blocks of filing transactions and invoices to a model supporting real-time payment of transaction fees at the time of filing submission. As existing prepaid transaction blocks are depleted, customers will automatically transition to payment via Automated Clearing House (ACH) Debit, and they will be assigned a fixed unit price according to a tiered structure long in place for SERFF. In 2021, each company will remain in the same tier as it did under the previous billing model.
- The Life Insurance Policy Locator application was enhanced on Feb. 5 to make it even more consumer-friendly, prevent duplicate requests, and increase validation. As of Jan. 30, consumers have submitted more than 262,726 requests, which have led to more than 99,532 matches of policies with claims of more than $1.29 billion.
b. Innovation and Technology

NAIC teams expand their leverage of Informatica PowerCenter, a data integration tool with automated source/target mapping capabilities. SBS eliminated 35 jobs by using Informatica PowerCenter to populate data marts used for various purposes in reducing operational support costs and technical debt.

The Tableau ecosystem at the NAIC continues to expand and improve. Currently, the PROD Tableau Server holds 167 workbooks and 259 data sources. The number of views of workbooks on the PROD server totaled 706,563 over the last six-month period.

The NAIC continues to work with two states to pilot the prototype solutions that use a Snowflake data warehouse as the access point to the financial and market conduct data currently accessed from the Oracle production database. A survey was sent to states in the fourth quarter of 2020 to gather information on the tools and technology used to access data, the tables accessed, and preferred migration time frames. Based on the information gathered, a migration road map was created.

c. Team Highlights

The NAIC leadership team and NAIC staff continue to learn about the Scaled Agile Framework (SAFe) and have earned numerous certifications. SAFe is the next step in the NAIC’s movement towards being more agile in its process and value delivery. SAFe provides a framework to apply Lean-Agile practices using proven methodologies, and it can positively influence:

- Alignment in process.
- A shared predictable cadence across the organization.
- Decentralized decision-making among the teams.
- Organization around customer value instead of silos.
- Transparency and communication of prioritized work.

4. Received a Portfolio Update and Project Status Reports

Sherry Stevens (NAIC) reported on the project portfolio. As of March, the NAIC’s technical project portfolio includes 22 active technical projects. Five projects have been completed since the last report.

Having no further business, the Information Systems (EX1) Task Force adjourned into regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings.
LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

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The Life Insurance and Annuities (A) Committee met April 12, 2021. The following Committee members participated: Marlene Caride, Chair, represented by Dave Wolf (NJ); Glen Mulready, Vice Chair (OK); Jim L. Ridling (AL); Trinidad Navarro (DE); Doug Ommen (IA); Dean L. Cameron (ID); Vicki Schmidt (KS); James J. Donelon (LA); Barbara D. Richardson represented by David Cassetty (NV); Linda A. Lacewell represented by Mona Bhalla (NY); Judith L. French (OH); Elizabeth Kelleher Dwyer and Sarah Neil (RI); Carter Lawrence represented by Brian Hoffmeister (TN); and Mark Afable and Richard Wicka (WI). Also participating was: Jodi Lerner (CA);

1. **Adopted its 2020 Fall National Meeting Minutes**

Commissioner Schmidt made a motion, seconded by Director Cameron, to adopt the Committee’s Dec. 7, 2020, minutes (see NAIC Proceedings – Fall 2020, Life Insurance and Annuities (A) Committee). The motion passed unanimously.

2. **Adopted the Reports of its Working Groups and Task Force**

Commissioner Donelon made a motion, seconded by Commissioner Schmidt, to adopt the following reports: the Accelerated Underwriting (A) Working Group, including its March 19 minutes (Attachment One); the Annuity Suitability (A) Working Group, including its March 9 and March 25 (Attachment Two), Feb. 22 (Attachment Two-A), and Dec. 14, 2020, (Attachment Two-B) minutes; the Life Insurance Illustration Issues (A) Working Group, including its March 10 (Attachment Three) and Feb. 23 (Attachment Four) minutes and an extension of the Request for NAIC Model Law Development; and the Life Actuarial (A) Task Force. The motion passed unanimously.

3. **Received an Update on the Special (EX) Committee on Race and Insurance Workstream Four’s Work**

Commissioner Afable, co-chair of the Special (EX) Committee on Race and Insurance (Special Committee) Workstream Four, provided an update to the Committee. He explained that the Special Committee met earlier in the day and received oral reports and recommendations from all its workstreams, including the Life Insurance and Annuities Workstream, Workstream Four. He said based on the recommendations of the workstreams, draft proposed charges from the Special Committee were distributed. He said the primary conclusion of Workstream Four, which was reflected in the proposed Special Committee charges, was that it had only just started to delve into the practices and barriers that potentially disadvantage minority and underserved populations in the life insurance and annuity lines of business. He said Workstream Four recommended that research and discussions continue to: 1) better determine the practices or barriers that disadvantage people of color and/or historically underrepresented groups; and 2) identify steps that can be taken to eliminate those barriers and disadvantages.

Commissioner Afable explained that the Special Committee proposed charges have Workstream Four continuing to research and formulate specific recommendations, as necessary, to address issues involving race and life insurance, such as: 1) the marketing, distribution and access to life insurance products in minority communities, including the role that financial literacy plays; 2) the impact of traditional life insurance underwriting on minority populations, considering the relationship between mortality risk and disparate impact; 3) disparities in the number of cancellations/rescissions among minority policyholders; and 4) whether there are other unresolved issues surrounding race and insurance in the life insurance industry that the Workstream should consider addressing. He said the Special Committee charges also recommend that the Accelerated Underwriting (A) Working Group, as part of its ongoing work to consider the use of external data and data analytics in accelerated life underwriting, include an assessment of and recommendations, as necessary, regarding the impact of accelerated underwriting on minority populations.

4. **Discussed and Adopted Modifications to its 2021 Charges**

Birny Birnbaum (Center for Economic Justice—CEJ) said he wrote a comment letter to the Committee recommending revisions to its 2021 charges. He said his suggested revisions: 1) offer revisions to make the charges better reflect the work actually being done by those groups; and 2) suggest the creation of a new working group, the Illustration Reengineering (A) Working Group, to take a fresh look at life insurance and annuity illustrations and advertising. He said this new working group would encompass the work of the current Annuity Disclosure (A) Working Group, but it would also conduct a thorough review, from a consumer perspective, of the entire life insurance annuity illustration regime. He said there are many problems with illustrations, not the
least of which is that illustrations are massive documents that mislead consumers as to product performance, while failing to adequately explain how products work. He said the regulatory guidance has been designed by actuaries, not by experts in consumer disclosures, with the result that product designs are developed to game the system. He also said guidance for annuities is very different from life insurance, even for products that are functionally similar, like indexed life and indexed annuities, which use the same accumulation approach, indexes and crediting features; but they have vastly different illustrations, even though they should perform similarly during the accumulation phase.

Mr. Birnbaum said the new Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold On or After December 14, 2020 (AG 49-A) is already being gamed by a company that is providing “showcase examples” of product accumulations, along with the required illustrations, in order to show an example based on assumptions prohibited in the actual illustration. He said life illustrations fail to show “sequence of returns risk” and show returns as if they are going to be the same every year, which is misleading. He said adding additional disclosures to what is already a 50-page to 80-page document is not a solution. He said illustrations are the key sales tool for investment-type life insurance and annuities, yet the current illustrations do not serve the intended purpose. He said there needs to be a coordinated review of life and annuity illustrations, including whether data-mined custom indices with little or no historical record should be permitted.

Mr. Birnbaum also suggested changing the name of the Life Insurance Illustration Issues (A) Working Group to the Life Insurance Policy Overview (A) Working Group to more accurately describe the limited scope of its work. He also suggested revising the Annuity Suitability (A) Working Group’s charge to reflect the fact that it completed revisions to the Suitability in Annuity Transactions Model Regulation (#275), and it is now working on a frequently asked questions (FAQ) document.

Commissioner Ommen said Mr. Birnbaum’s suggested Illustration Reengineering (A) Working Group appears to be a broader endeavor apart from the Annuity Disclosure (A) Working Group, which he agrees should be entertained by the Committee once it receives additional information and considers how such an endeavor might fit in to the larger work commitments and responsibilities of the Committee this year. He explained that before the Committee undertakes a new working group and charge, there should be discussion to ensure that there is sufficient state insurance regulator and commissioner support to avoid repeating the situation at hand with the Annuity Disclosure (A) Working Group. He reiterated that the revisions to Model #245 for participating income annuities that were adopted by the Committee in 2018 and held should be forwarded to the Executive (EX) Committee and Plenary for consideration during the Summer National Meeting.

Commissioner Ommen explained that the Annuity Disclosure (A) Working Group is charged to “review and revise, as necessary, Section 6-Standards for Annuity Illustrations in the Annuity Disclosure Model Regulation (#245) to take into account the disclosures necessary to inform consumers in light of the product innovations currently in the marketplace.” He said the Working Group is chaired by Mike Yanacheak (IA), chief actuary with the Iowa Department of Insurance (DOI). Commissioner Ommen said the Working Group has been in existence for more than four years. He explained that it revised the Annuity Disclosure Model Regulation (#245) to allow for participating income annuities, but it has been struggling to draft language to allow the illustration of indices that have been in existence for less than 10 years, under certain circumstances. He said the prohibition in Model #245 was intended to prevent gaming the creation of a combination of indices for the purposes of creating favorable illustrations. He said only five states have adopted the version of Model #245 prohibiting such illustrations. He said because the majority of states do not restrict these illustrations, there has not been the push and commissioner support necessary to achieve consensus on the revisions to Model #245. He said Iowa has adopted the most recent version of Model #245 and is moving forward with a rule to allow the illustrations. He said at this point, he would leave it to the states to draft their own language or do what they are doing in Iowa and promulgate a regulation on the matter.

Commissioner Ommen said Mr. Birnbaum’s suggested Illustration Reengineering (A) Working Group appears to be a broader endeavor apart from the Annuity Disclosure (A) Working Group, which he agrees should be entertained by the Committee once it receives additional information and considers how such an endeavor might fit in to the larger work commitments and responsibilities of the Committee this year. He explained that before the Committee undertakes a new working group and charge, there should be discussion to ensure that there is sufficient state insurance regulator and commissioner support to avoid repeating the situation at hand with the Annuity Disclosure (A) Working Group. He reiterated that the revisions to Model #245 for participating income annuities that were adopted by the Committee in 2018 and held should be forwarded to the Executive (EX) Committee and Plenary for consideration during the Summer National Meeting.

Ms. Lerner asked whether Commissioner Ommen would share the regulation in Iowa. Commissioner Ommen said it is still a work in progress, but he said he would share it as soon as it is available. Jason Berkowitz (Insured Retirement Institute—IRI) said the IRI did not have a position with respect to Mr. Birnbaum’s suggested new Illustration Reengineering (A) Working Group, but he asked that the Committee not presuppose any conclusions within any new charge, such as that life insurance and annuity products are identical, when they are in fact different products.
Commissioner Ommen made a motion, seconded by Commissioner Afable, to disband the Annuity Disclosure (A) Working Group once the Executive (EX) Committee and Plenary consider adoption of the participating income annuity revisions to Model #245 adopted and then held by the Life Insurance and Annuities (A) Committee at the 2018 Summer National Meeting. The motion passed unanimously.

Mr. Wicka spoke to Mr. Birnbaum’s suggested revisions to the Life Insurance Illustration Issues (A) Working Group. He explained that the Working Group has met twice over the past couple of months—March 10 and Feb. 23. He said the Working Group made a lot of progress, and it is very close to completing alternative draft versions of a sample policy overview document for term life policies. He said one version shows the sample pre-underwriting, the other post-underwriting. He said the Working Group has been developing these alternative versions to aid the Committee in providing guidance to the Working Group with respect to the timing of the delivery of this policy overview document the Committee has been working on. Although the Working Group agreed to revisions on the Committee’s last call, the Committee wants to have completed, revised versions of the policy overview and corresponding revised versions of the Life Insurance Disclosure Model Regulation (#580) for the Working Group to look at and vote to bring to the Committee to provide guidance to the Working Group on next steps. He suggested holding off on making revisions to the Working Group charges at this time and revisiting the issue when the Committee has the drafts before it to review. He pointed out that the Working Group has been working under this charge for a while, and he said he does not believe any changes are necessary for the Working Group to complete its charge.

Commissioner Ommen said the Retirement Security (A) Working Group has a charge to “explore ways to promote retirement security consistent with the NAIC’s continuing ‘Retirement Security Initiative.’” He said this has been a charge of the Committee for a number of years and an NAIC priority for years before that. He explained that Commissioner Stephen C. Taylor (DC) chaired the Working Group a couple of years ago; held a number of conference calls; heard presentations from groups who work on this issue, like the Children’s Financial Network (CFN) and the National Financial Educators Council (NFEC); and reached out to groups like the American Association of Retired Persons (AARP). The Working Group also heard from Funded Consumer Representative Brenda Cude (University of Georgia) and Karrol Kitt (University of Texas at Austin). Commissioner Ommen said the issue of retirement security permeates all that the NAIC does, including the most recent focus of the NAIC and the Special Committee. He said new charges coming to the Committee from the Special Committee encompass the spirit of this charge in an ongoing way. He said given the work undertaken by Commissioner Taylor and the new charges coming to the Committee under the race and diversity strategic priorities of the NAIC, it may be reasonable to conclude that the Working Group’s charge has been fulfilled.

Mr. Berkowitz commended the efforts of the Working Group over the years, and he said he does not want the NAIC to lose sight of this critical issue. He said there is a lot of good that can be done through the insurance regulatory community to help people prepare for their retirement. He said the IRI stands ready to support the NAIC in its efforts, whether it is through this Working Group or another mechanism.

Commissioner Ommen made a motion, seconded by Superintendent Dwyer, to disband the Retirement Security (A) Working Group, as having fulfilled its charge. The motion passed unanimously.

5. Discussed Life Insurer Practices Related to COVID-19

Commissioner Mulready said there are three issues he wants to raise with respect to insurer practices and COVID-19. The first is a letter from the Consumer Federation of America (CFA). This letter asks the NAIC to develop a model rule for life insurance underwriters who might delay or deny coverage for people who have or had COVID-19, and it also asks the industry to make COVID-19 underwriting rules public and reasonable. He said the second is an issue the Interstate Insurance Product Regulation Commission (Compact) has encountered; i.e., life insurance underwriting questions related to COVID-19 vaccinations. He said the third issue involves a rumor that has been brought to the attention of a few states that the Committee knows of, as well as the Compact, that life insurance claims have not been paid because the cause of death was the COVID-19 vaccination. The assertion is that the life insurance company claims the vaccine was not U.S. Food and Drug Administration (FDA)-approved, and the deceased signed a release before receiving the shot.

Bob Hunter (CFA) said the New York Times reported that over 31 million Americans have had or currently have COVID-19, and millions more than that probably have had it with mild or no symptoms. He said in short, this as an issue that touches many, many people. He said the CFA is simply asking for more transparency. He said the CFA is not asking for life insurers to stop reasonable underwriting practices, but consumers should be able to find out what those practices are. He said the pandemic is
causing an increasing number of people to realize their need for life insurance, and there should be some guidelines for consumers to understand what insurers are going to be looking for and whether they will need to have a COVID-19 vaccination or a negative COVID-19 test, instead of having to go blindly from company to company. He said the CFA has asked major insurance companies to be more transparent, but they have not responded, so that is why the CFA is asking the Committee to consider developing a model rule requiring transparency and reasonable standards for processing life insurance applications in the COVID-19 and post-COVID-19 era.

Superintendent Dwyer said when COVID-19 first emerged, there were several states that did not allow life insurance applications to ask questions about COVID-19. She said a significant percentage of life insurance is written through the Compact, and NAIC members should be aware of the position the Compact has taken with respect to COVID-19 related questions on life insurance applications.

Karen Schutter (Compact) explained that the Compact established a multi-state public entity, the Interstate Insurance Product Regulation Commission, which serves as an instrumentality of the 46 compacting states who come together to develop and adopt Uniform Standards to allow companies to submit forms to the Compact for review and approval under those Uniform Standards. She said it is front-end regulation promoting efficiency and uniform requirements for life insurance, annuities, long-term care insurance (LTCI), and disability income insurance. She said in March 2020, the Compact Office started to see life application forms that had questions related to COVID-19 testing and diagnosis. She explained that the Compact Office, through its monthly communication with its members, reported on the type of questions it was seeing, and more importantly the requirements for such questions under the Uniform Standards. She said the Compact also developed a COVID-19 resource page in its website insurancecompact.org with a detailed list of FAQ.

Ms. Schutter said at the start of the pandemic, there were questions about travel, and the ability to exclude certain travel was an emerging concern. She said the Uniform Standards permit questions about foreign travel and residency outside the U.S., provided that the question is limited to a two-year look back and forward. She said the Uniform Standards permit exclusion or limitation of foreign travel or residency only if permitted by state law in the state where the policy is delivered or issued. In other words, exclusions based on information in the underwriting follow state law.

Ms. Schutter said the Compact’s COVID-19 FAQ also provide detailed information regarding the types of medical questions that can be asked in application forms. She explained that open-ended questions requiring a self-diagnosis are prohibited. She said questions like whether you think you have COVID-19, whether you have had trouble breathing, and whether you have been exposed to someone with COVID-19 are not allowed. She said medical questions on an application must be in a prescribed format under the Uniform Standards, and must have specified look back periods, such as two, five or 10 years. She said diagnostic questions must be phrased in terms of whether an applicant has been “diagnosed, treated, tested positive for, or been given medical advice for” by a member of the medical profession regarding the specific condition.

Ms. Schutter said the Compact has also reported to its members the filings approved on their behalf, which include applications with COVID-19 questions. She said an approximate total of 60 filings with applications have been approved over the last year. She said under the Uniform Standards, a life insurance policy is prohibited from including an exclusion for death from a specified condition, such as COVID-19. She said the Compact has not seen such an objectionable provision in a form. She said another aspect of COVID-19 filing activity the Compact has seen is companies updating their filings to change the delivery format of their application from paper to electronic.

Ms. Schutter said an important point to remember is that there are many ways an insurer can elicit information about an applicant with respect to the testing or diagnosis of COVID-19 without asking the direct question. For example, the application can ask if the proposed insured received inpatient or outpatient treatment in a hospital, clinic or medical facility, and the insurer can also obtain medical records in addition to the medical questions on an application.

Ms. Schutter explained that concerns with how information is used in the underwriting process are outside the scope of the Compact. She said the Uniform Standards make it very clear that certain exclusions based on the underwriting process follow state law and apply to Compact-approved applications and policies. She said some of the most common exclusions are avocation, aviation, occupation, foreign travel and foreign residency.

Ms. Schutter said the Compact would appreciate guidance from the Committee as the policy experts with respect to the COVID-19 vaccination question. She said about a month ago, the Compact received an application with a question of whether the applicant received a COVID-19 vaccine, including asking for the dates of the first and second shot and the manufacturer.
Ms. Schutter said at this point, the Compact Office considers this question objectionable under its Fairness standard because this vaccine is not yet widely available and state insurance regulation has not set public policy regarding its use in underwriting. She said the Compact Office stands ready to provide further information.

Commissioner Mulready said in his interactions with media and consumers, he sticks to the fact that life insurance policies are contracts, there are no exclusions for medical conditions, and exclusions cannot be added later. Brendan Bridgeland (Center for Insurance Research—CIR) said he is a member of the advisory board for the Compact, and he has discussed these application questions with Ms. Schutter. He said he initially thought that some of the questions were problematic, but any concerns he had initially have been addressed. He said he agrees with Ms. Schutter with respect to the vaccination questions, and the situation is evolving. He said even if someone got vaccinated initially, there may be booster requirements in the future, and it is unclear how that issue could be handled with life insurance, which raises the question of the relationship between the question and the risk involved.

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.
Accelerated Underwriting (A) Working Group
Virtual Meeting (in lieu of meeting at the 2021 Fall National Meeting)
March 19, 2021

The Accelerated Underwriting (A) Working Group met March 19, 2021. The following Working Group members participated: Mark Afable, Chair (WI); Grace Arnold, Vice Chair (MN); Jason Lapham (CO); Russ Gibson (IA); Rich Piazza (LA); Rhonda Ahrens and Laura Arp (NE); Chris Aufenthie (ND); Lori Barron (OH); Elizabeth Kellher Dwyer (RI); and Lichou Lee (WA). Also participating were: Jodi Lerner (CA); and Nour Benchaaboun (MD).

1. Received a Report from the Ad Hoc Drafting Group

Commissioner Afable reminded the Working Group that there were two groups of state insurance regulators that had volunteered to participate in two efforts: 1) a drafting group—to collect the information from the Working Group’s presentations and develop language for a work product for the larger Working Group and interested parties to react to; and 2) a liaison group—to monitor and apprise the drafting group of the activities of other NAIC groups that are touching on many of the same topics as the Accelerated Underwriting (A) Working Group. He explained that these two groups have combined efforts and now comprise a single drafting group led by Commissioner Arnold. He said the focus is to draft an educational report to explore accelerated underwriting (AU) in life insurance and offer guidance to state insurance regulators, industry, consumer advocates and other stakeholders.

Commissioner Arnold updated the Working Group on the newly merged drafting group’s progress. She said the drafting group last met on March 10 and is scheduled to meet every three weeks to continue working on drafting language for an educational report. She said the report will be narrowly focused on life insurance underwriting to avoid conflicting with the work of other NAIC groups, such as the Innovation and Technology (EX) Task Force, the Big Data and Artificial Intelligence (EX) Working Group, the Casualty Actuarial and Statistical (C) Task Force, and the Privacy Protections (D) Working Group.

Commissioner Arnold said the drafting group is working from the Nov. 17, 2020, outline (see NAIC Proceedings Fall 2020, Life Insurance and Annuities (A) Committee, Attachment Two) that was distributed to the Working Group during its Nov. 17, 2020, meeting. She said state insurance regulators have volunteered to work on language to fill in the outline. She said the goal is to transform the outline into more of a paper that can be exposed for comment. She said the drafting group hopes to have some sections of the outline ready to expose for comment shortly after its next meeting, scheduled for March 31.

Birny Birnbaum (Center for Economic Justice—CEJ) said he had submitted comments on March 18 suggesting revisions to the Nov. 16, 2020, outline. Ms. Arnold thanked Mr. Birnbaum for his comments and agreed to reach out with any questions once the drafting group has a chance to review his suggestions. Peter Kochenburger (University of Connecticut School of Law) said that the report should incorporate and build upon the NAIC Principles on Artificial Intelligence (AI Principles). He said one of the purposes of the AI Principles is to guide, which would be particularly useful in the context of this report. Commissioner Afable said he agrees that the AI Principles were intended to guide the work undertaken by other NAIC groups, like this Working Group, and that the AI Principles would be taken into account in the Working Group’s report.

Having no further business, the Accelerated Underwriting (A) Working Group adjourned.
The Annuity Suitability (A) Working Group of the Life Insurance and Annuities (A) Committee met March 25 and March 9, 2021. The following Working Group members participated: Doug Ommen, Chair (IA); Amanda Baird, Vice Chair, and Michelle Brugh Rafeld (OH); Jimmy Gunn and Steve Ostlund (AL); Jodi Lerner (CA); Fleur McKendell (DE); Dean L. Cameron (ID); Shannon Lloyd and Tate Flott (KS); Renee Campbell (MI); Bruce R. Range, Martin Swanson and Tom Green (NE); Keith Nyhan and Denise Lamy (NH); Andrew Schallhorn and Cuc Nguyen (OK); Brian Hoffmeister (TN); Matt Gendron and Sarah Neil (RI); and Richard Wicka (WI). Also participating was: Robert Wake (ME).


The Working Group met Feb. 22, 2021, and Dec. 14, 2020. During these meetings, the Working Group discussed the draft Frequently Asked Questions (FAQ) guidance document (see NAIC Proceedings – Spring 2021, Life Insurance and Annuities Committee, Attachment Two-B1), which the Working Group developed as one way for it to complete the second part of its 2020 charge to “[c]onsider how to promote greater uniformity across NAIC member jurisdictions.” The Working Group also discussed the comments received on the draft and revisions to the draft based on the comments received.

Mr. Ostlund made a motion, seconded by Ms. Rafeld, to adopt the Working Group’s Feb. 22, 2021 (Attachment Two-A) and Dec. 14, 2020, minutes (Attachment Two-B). The motion passed unanimously.

2. **Discussed Comments on a Draft FAQ Guidance Document**

Commissioner Ommen said that during its Feb. 22 meeting, the Working Group began discussion, but did not finish, of revisions based on the comments received to the draft FAQ guidance document. The Working Group continued with the discussion of comments received on Question 9 in the conflict of interest section using the comment chart NAIC staff developed (see NAIC Proceedings – Spring 2021, Life Insurance and Annuities (A) Committee, Attachment Two-B2).

Commissioner Ommen directed the Working Group’s attention to the Joint Trades’—the American Council of Life Insurers (ACLI), the Committee of Annuity Insurers (CAI), the Financial Services Institute (FSI), the Indexed Annuity Leadership Council (IALC), the Insured Retirement Institute (IRI) and the National Association for Fixed Annuities (NAFA)—suggested revisions to Question 9. Jason Berkowitz (IRI) said the Joint Trades submitted a supplemental comment letter revising its suggested revisions to Question 9. Jason Berkowitz (IRI) said the Joint Trades submitted a supplemental comment letter revising its suggested revisions to Question 9. After considering this question, the Working Group should add a question describing why the Working Group decided to define “material conflict of interest” as not including cash or non-cash compensation. The Working Group discussed Mr. Birnbaum’s suggestion. After additional discussion, the Working Group decided to add a new question reflecting Mr. Birnbaum’s suggestion. The Working Group also decided to include the Joint Trades’ revised suggested revisions to Question 9 in the next FAQ draft for additional discussion during its next meeting.

The Working Group next discussed the suggested revisions to Question 10, which discusses what a producer must do to identify and avoid or reasonably manage a material conflict of interest as provided in Section 6A(3). The Federation of Americans for Consumer Choice’s (FACC’s) and the Joint Trades’ suggested revisions to this question. After discussion, the Working Group decided to accept the Joint Trades’ suggested revisions.

No comments were received on Question 11.
of such language of potentially narrowing the scope or intent the language in Section 6C(2)(h). In addition, for similar reasons, the Working Group decided not include language related to the intent of “limited period of time.”

The Working Group next discussed the Joint Trades’ suggestion to add a new FAQ under a new Safe Harbor section. The proposed question discusses whether insurers and producers are required to comply with the requirements of the revised Suitability in Annuity Transactions Model Regulation (#275) if they are acting in compliance with rules imposed by other regulators that meet or exceed the revised model’s requirements—so-called “comparable standards.” Mr. Berkowitz said that the Joint Trades suggest adding this question because there seems to be some differences of opinion in terms of what was intended by the safe harbor provision. This question is meant to clarify this for the states and based on their understanding of its intent, which is that recommendations and sales of annuities made in compliance with comparable standards shall satisfy the revised model’s requirements.

The Working Group discussed to what extent the comparable standards in the safe harbor apply to specific requirements in the revised model, such as producer training. Mr. Berkowitz acknowledged that for some of the comparable standards, those standards may not always have listed the explicit training requirements in Section 7 of the revised model. However, he said the Joint Trades believe that it would be difficult for a registered broker-dealer or a registered investment advisor to satisfy their U.S. Securities and Exchange Commission (SEC) best interest rule obligations or fiduciary obligations if they are not properly training on the products they are recommending.

Commissioner Ommen acknowledged Mr. Berkowitz’s comments, but he noted that one issue that remains unclear is whether training provided for variable annuities is going to be adequate in terms of comparability with training for fixed or fixed indexed annuities. Wes Bissett (Independent Insurance Agents & Brokers of America—IIABA) expressed his concern with the Joint Trades’ proposed new question and answer and their interpretation of the safe harbor provision. He said the IIABA interprets the safe harbor as applying to a financial professional’s recommendations and sales of annuities—not broadly as an exemption from all the supervisory obligations for insurers. Mr. Berkowitz disagreed with Mr. Bissett’s characterization that the Joint Trades’ interpretation of the safe harbor as an exemption from all supervisory obligations for insurers. He pointed out the language in the new question on the subject. He also explained how the Joint Trades view the safe harbor provision with respect to an insurer’s supervisory responsibilities. Commissioner Ommen explained his concerns with the Joint Trades’ question and answer, which appears to exempt financial professionals relying on the same harbor and its comparable standard provisions from the revised model’s requirements. The Working Group discussed his concerns. After additional discussion, the Working Group deferred deciding on the Joint Trades’ suggested new FAQ to allow the Joint Trades time to submit revised language addressing the Working Group’s concerns.

3. Discussed Producer Training Comments on a Draft FAQ Guidance Document

Commissioner Ommen said NAIC staff prepared a comment chart reflecting the comments and suggested revisions to the FAQ guidance document on the revised model’s producer training requirements (see NAIC Proceedings – Spring 2021, Life Insurance and Annuities Committee, Attachment Two-B3). He said he would like to use this chart to facilitate the Working Group’s discussion. There was no objection.

Commissioner Ommen explained that most of the comments received on the producer training section of the FAQ suggest adding new questions to identify and address issues the FAQ did not cover or were not fully developed. Mr. Berkowitz discussed the Joint Trades’ suggested new questions and answers on producer training completed prior to a state’s adoption of the model. He explained that the Joint Trades wanted to clarify this issue to assist producers and the states in understanding when and under what circumstances a producer would need to take the updated four-hour credit training or the one-hour credit alternative training. He said the intent of the Joint Trades’ suggested questions was to help ensure that a producer does not have to unnecessarily be required to take either the four-hour credit course or the one-hour credit course more than one time as the states move to adopt the revised model.

Commissioner Ommen acknowledged that this issue with training has arisen in some states that have adopted the revised model. The Working Group discussed the Joint Trades’ suggested revisions. Mr. Gendron suggested that the Joint Trades’ questions could be more concise. Mr. Berkowitz agreed that it could be possible, but he noted that there has been a lot of confusion related to these issues and that one goal of the Joint Trades’ questions was to provide additional context and background on the issue. Mr. Wicka suggested the Joint Trades’ answer for its first question could be revised to state: “Yes, the revised model allows for states to recognize courses taken in other states before the model is adopted in their state. The revised model is intended to provide for reciprocity so producers that operate in multiple jurisdictions would not have to retake the same training multiple times.” Mr. Birnbaum expressed support for Mr. Wicka’s suggested revisions, but he said the Joint Trades’ questions
also could be simplified. He provided suggested language. After additional discussion, the Working Group decided to try to simplify the Joint Trades’ suggested questions and answers. The Working Group also asked Mr. Birnbaum to submit his suggested language to NAIC staff for the Working Group’s consideration during its next meeting.

The Working Group next discussed the Joint Trades’ suggested revisions to Question 13 in the FAQ, which concerns whether a producer must complete the additional training on the best interest standard of conduct even if they have already completed the existing annuity training requirements with the prior suitability standard of conduct. The Joint Trades suggest revising Question 13 to have it apply only to producers who are not relying on the safe harbor in Section 6E.

Mr. Berkowitz said the Joint Trades’ suggested revision supports its belief that the safe harbor provision applies to producer training. He acknowledged that the Joint Trades’ position on that issue is still being debated and that additional discussion of the issue will most likely occur later during the meeting. The Working Group discussed the Joint Trades’ suggestion, specifically the Joint Trades’ interpretation that the safe harbor extends to producer training. Mr. Berkowitz discussed the Joint Trades’ reasoning for its interpretation. He said the Joint Trades submitted additional suggested revisions on the safe harbor issue for the Working Group’s consideration (Attachment Two-C). Some Working Group members discussed why they disagreed with this interpretation because those financial professionals using the safe harbor provision are still producers and would need to take the training described in Section 7 of the model. Mr. Bissett discussed the IIABA’s position on the issue and noted that the IIABA submitted written comments to the Working Group for its consideration on the issue (Attachment Two-D). After additional discussion, the Working Group requested that Mr. Berkowitz provide revised language for the Working Group’s consideration that would include the ability for state insurance regulators to review and approve a training course that a producer, who is a dual registrant, believes is substantially similar to the state’s training course and would satisfy the model’s training requirements. The Working Group also agreed that the Joint Trades should use some of the language offered by the IIABA to redraft its question and answer.

The Working Group next discussed the Joint Trades’ suggested new FAQ on the appropriateness of a producer taking the four-hour training course versus the one-hour training course. After discussion, the Working Group agreed that adding such a question would be beneficial. However, the Working Group agreed that it could be simplified and made clearer. Ms. Rafeld and Mr. Gendron agreed to work with Mr. Berkowitz to revise the FAQ for the Working Group’s consideration at its next meeting.

The Working Group discussed the Joint Trades’ suggested new FAQ to address situations when a producer fails to timely complete the updated four-hour training course or the one-hour training course. After discussion, the Working Group agreed that adding this FAQ would be helpful to provide clarification for producers. Ms. Rafeld agreed to work Mr. Berkowitz to simplify the FAQ for the Working Group’s consideration during its next meeting. Mr. Birnbaum offered suggested language to clarify the FAQ. Mr. Berkowitz and Ms. Rafeld agreed to take Mr. Birnbaum’s suggested language into consideration as they work to clarify and simplify the Joint Trades’ suggested new FAQ.

4. Discussed a New FAQ Conflict of Interest Question

Mr. Birnbaum discussed his suggested language for a new FAQ explaining why cash and non-cash compensation is not considered a material conflict of interest (Attachment Two-E). This new FAQ would precede Question 9. The Working Group discussed the suggested language. Ms. Baird suggested that the CEJ’s suggested language was a good beginning. However, she said she believes the Working Group should review for discussion later the several states’ suggested language because it provides more background and context on the issue. She explained why that was important. The Working Group deferred deciding on the FAQ language until the Working Group’s next meeting.

The Working Group decided its next meeting would be sometime in late April or early May, during which it hopes to complete its work.

Having no further business, the Annuity Suitability (A) Working Group adjourned.
The Annuity Suitability (A) Working Group of the Life Insurance and Annuities (A) Committee met Feb. 22, 2021. The following Working Group members participated: Doug Ommen, Chair (IA); Amanda Baird, Vice Chair, represented by Michele Brugh Rafeld (OH); Jimmy Gunn and Steve Ostlund (AL); Jodi Lerner (CA); Tate Flott (KS); Renee Campbell (MI); Bruce R. Ramge (NE); Keith Nyhan (NH); Brian Hoffmeister (TN); Matt Gendron and Sarah Neil (RI); and Richard Wicka (WI).

1. Discussed Comments on a Draft FAQ Guidance Document

During the Working Group’s meeting at the 2020 Summer National Meeting, the Working Group agreed to distribute for a 30-day public comment period a draft Frequently Asked Questions (FAQ) guidance document (see NAIC Proceedings – Spring 2021, Life Insurance and Annuities (A) Committee, Attachment Two-B1), which the Working Group developed as one way for it to complete the second part of its 2020 charge to “[c]onsider how to promote greater uniformity across NAIC member jurisdictions.” The purpose of this guidance document is to assist the states as they move forward with adopting the revised Suitability in Annuity Transactions Model Regulation (#275), which added a best interest standard of conduct for insurers and producers, through either an administrative or a legislative process.

Commissioner Ommen said the Working Group received several comment letters in response to its request for comments and discussed the comments during its Dec. 14, 2020, meeting. He said NAIC staff incorporated the comments received into a chart (see NAIC Proceedings – Spring 2021, Life Insurance and Annuities (A) Committee, Attachment Two-B2), which he would like to use to facilitate the Working Group’s discussion of potential revisions to the guidance document. There was no objection to his suggestion.

Commissioner Ommen directed the Working Group to the Federation of Americans for Consumer Choice’s (FACC) suggestion for Question 1, which explains why the NAIC decided to revise Model #275 to add a best interest standard of conduct, to replace the word “harmonization” with “compatibility.” There was no objection to accepting the suggested revision.

The Working Group next discussed the FACC’s and the Joint Trades’—the American Council of Life Insurers (ACLI), the Committee of Annuity Insurers (CAI), the Financial Services Institute (FSI), the Indexed Annuity Leadership Council (IALC), the Insured Retirement Institute (IRI) and the National Association for Fixed Annuities (NAFA)—suggested revisions to Question 2. This question explains how Section 989J of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) applies to the revised model. Commissioner Ommen asked for comments from Working Group members. He said the suggested revisions are meant to be clarifying. After discussion, the Working Group agreed to accept the Joint Trades’ suggested revisions.

The Working Group next discussed the Joint Trades’ suggestion to add a question discussing the process the Working Group used to develop and adopt the Model #275 revisions. After discussion, the Working Group decided not to add the suggested question because such a question was unnecessary.

The Working Group next discussed Question 3, which relates to the provision in the revised model providing an exemption to for annuities purchased in response to a direct response solicitation. Commissioner Ommen said he believes the Joint Trades’ suggestion possibly would expand the exemption with addition of “telephone” communications. Wes Bissett (Independent Insurance Agents & Brokers of America—IIABA) noted the IIABA’s comments concerning the direct response solicitation exemption in Model #275. He also agreed that the Joint Trades’ suggested revisions appear to expand the exemption. Jason Berkowitz (IRI) said the intent of the Joint Trades’ suggested revisions were to align it with the definition of “direct response solicitation” in the Life Insurance and Annuities Replacement Model Regulation (#613). After discussion, the Working Group decided not to accept adding the word “telephone,” but it agreed to accept the Joint Trades’ suggestion to delete “a digital platform.”

The Working Group next discussed Question 4, which describes the best interest standard of conduct and how a producer or insurer would satisfy it. Commissioner Ommen said the FACC suggests a few revisions to more closely align the answer to the model’s language. The Working Group agreed to accept the FACC’s suggested revisions.
The Working Group next discussed Question 5, which describes what types of recommendations fall under the best interest standard of conduct. Commissioner Ommen said the FACC suggests additional language specifying that insurers are only expected to supervise recommendations that result in an application being submitted to the insurer. After discussion, the Working Group decided not to accept the suggested revision.

The Working Group next discussed Question 6, which concerns the application of the best interest standard of conduct to a producer who never meets the client but assists a producer in making a recommendation to that client. Commissioner Ommen noted the importance of this question given its potential application to independent marketing organizations (IMOs). He said the Joint Trades and the FACC submitted suggested revisions. Mr. Gendron expressed support for the FACC’s suggestion to add words “the standard applies, if.” The Working Group did not believe it was necessary to include a definition of “material control or influence.” After discussion, the Working Group agreed to add language from the model describing activities that, in and of themselves, would not constitute material control or influence instead of adding a definition of “material control or influence.” The Working Group also agreed to modify the FACC’s language to add “the standard can apply.”

The Working Group next discussed Question 7, which describes the provisions of Section 6A(1)(c) of the revised model requiring producers to be held to standards applicable to other producers with similar authority and licensure. Commissioner Ommen said the Joint Trades and the FACC suggest revisions to this question. The Working Group discussed what is meant by the language “similar authority and licensure” with respect to the care obligation, which is extensively outlined in the model. Mr. Gendron expressed concern with Joint Trades’ suggested language which appears to be limiting.

Duane Thompson (XY Planning Network) discussed the XY Planning Network’s comments on Question 7. The XY Planning Network suggests revisions to the question to include more information to remind and guide producers holding other licenses that require fiduciary accountability to the overlapping regulatory authorities with respect to market conduct standards. Mr. Thompson said it should be made clear that in one capacity, such as that of an investment adviser representative (IAR), an individual has a fiduciary obligation to consider reasonable products and alternative products or strategies that are best-suited, at the time of the recommendation, in meeting the client’s financial goals and objectives. In addition, the XY Planning Network suggests the question should disclose that, separately in the capacity of an insurance producer, product availability is limited to those insurance contracts for which the producer is licensed to sell.

The Working Group discussed the suggested revisions, including the XY Planning Network’s comments, and whether the current language needed to be clarified with respect to dual registrants. The Working Group decided not to accept the Joint Trades’ or the FACC’s suggested revisions. The Working Group asked Mr. Thompson and Mr. Gendron to work together to provide language for the Working Group’s consideration that would clarify the question’s application to dual registrants, who may be subject to a different standard of conduct, such as a fiduciary standard of conduct, than the best interest standard of conduct provided in the revised model.

The Working Group next discussed Question 8. Question 8 describes how a producer or insurer can use the “Insurance Agent (Producer) Disclosure for Annuities” form to satisfy the disclosure obligation by providing it during an initial client meeting and/or at later date when it requires updating. The Joint Trades and the FACC submitted comments. The Working Group agreed to accept the Joint Trades’ suggestion to add “or sale of an annuity” for consistency with the revised model’s language. Some Working Group expressed concern with the FACC’s suggested revisions related to the timing of providing the form. After additional discussion, the Working Group decided not to accept the FACC’s suggested revisions.

The Working Group discussed the Joint Trades’ suggestion to add a new question to the FAQ guidance document on the application of the safe harbor provision in Section 6E of the revised model with respect to providing the Insurance Agent (Producer) Disclosure for Annuities” form. The Working Group agreed that it was unnecessary to add such a question, particularly in this section of the FAQ guidance document.

The Working Group next discussed Question 9. Question 9 describes Section 5I(2) of the revised model concerning the definition of “material conflict of interest.” The Joint Trades and the FACC provided comments. Commissioner Ommen noted his concerns with providing examples and the possibility of stakeholders believing these examples are the only examples that meet the definition of “material conflict of interest.” Mr. Berkowitz directed the Working Group’s attention to the Joint Trades’ comments on this question it submitted following the Working Group’s previous meeting. He discussed the Joint Trades’ intent behind its comments. He also suggested that the Joint Trades would not object to not including examples.
Commissioner Ommen said the Working Group would need to schedule another meeting to continue its discussion of revisions to the FAQ guidance document beginning where it ended during this meeting with Question 9. He said the Working Group also needs to discuss the training piece. The Working Group requested NAIC staff to prepare a working draft of the FAQ guidance document for the Working Group’s consideration during its next meeting reflecting the discussion during this meeting.

Having no further business, the Annuity Suitability (A) Working Group adjourned.

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1. Discussed Comments on a Draft FAQ Guidance Document

Commissioner Ommen said during the Working Group’s meeting at the 2020 Summer National Meeting, the Working Group agreed to distribute for a 30-day public comment period a draft Frequently Asked Questions (FAQ) guidance document (Attachment Two-B1), which the Working Group developed as one way for it to complete the second part of its 2020 charge to “[c]onsider how to promote greater uniformity across NAIC member jurisdictions.” He explained that the purpose of this guidance document is to assist the states as they move forward with adopting the revised Suitability in Annuity Transactions Model Regulation (#275), which added a best interest standard of conduct for insurers and producers, through either an administrative or a legislative process.

Commissioner Ommen said the Working Group received several comment letters in response to its request for comments by Oct. 2, 2020. He said NAIC staff incorporated the comments received into a chart (Attachment Two-B2), which he would like to use to facilitate the Working Group’s discussion of the comments. There was no objection to his suggestion.

The Working Group discussed the comments received on Question 1, which explains why the NAIC decided to revise Model #275 to add a best interest standard of conduct. Kim O’Brien (Federation of Americans for Consumer Choice—FACC) said the FACC suggests replacing the word “harmonization” with “compatibility.” She said this change would clarify how the revised model should work with other regulatory authorities. The Working Group took this suggestion under advisement.

The Working Group discussed the comments received on Question 2. This question explains how Section 989J of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) applies to the revised model. Commissioner Ommen said the FACC and the Joint Trades—the American Council of Life Insurers (ACLI), the Committee of Annuity Insurers (CAI), the Financial Services Institute (FSI), the Indexed Annuity Leadership Council (I TLC), the Insured Retirement Institute (IRI), and the National Association for Fixed Annuities (NAFA)—submitted comments. Ms. O’Brien said the FACC’s comments are intended to ensure that the explanation of Section 989J is accurate. Jason Berkowitz (IRI) said the Joint Trades suggest revisions to Question 2 to also ensure its accuracy and emphasize state insurance regulatory authority over fixed and fixed indexed annuities. Wesley Bissett (Independent Insurance Agents and Brokers of America—IIABA) expressed concern with the suggested revisions because the IIABA believes the revisions could possibly expand the scope of the Section 989J exemption. Commissioner Ommen said the Working Group would take a closer look at Section 989J to make sure Question 2 is consistent.

The Working Group discussed the comments received on Question 3, which relates to the provision in the revised model on exemptions. Gary Sanders (National Association of Insurance and Financial Advisors—NAIFA) suggested that the proposed answer to the question does not actually answer the question. Mr. Berkowitz said the Joint Trades suggested revision to the question aligns with the actual language in the model. Ms. Meyers said the ACLI is concerned with the reference to a simulated voice; as such, she suggested...
the revisions. The Working Group discussed the meaning of a “direct response solicitation.” Mr. Birnbaum suggested that the Working Group focus on the idea of the meaning of a “solicitation without a recommendation” and try to clarify that instead of the medium used to make the solicitation. Mr. Sanders reiterated the NAIFA’s concern with the exemption in Section 4A because it exempts certain recommendations from having to comply with the revised model’s provisions. The Working Group did not make any decisions based on the discussion. It plans to revisit the question and potentially consider revisions reflecting the discussion later.

The Working Group next discussed Question 4, which describes the best interest standard of conduct and how a producer or insurer would satisfy it. Ms. O’Brien said the FACC recognizes that the purpose of the FAQ guidance document is not to restate what is in the revised model word-for-word, but the FACC believes it is important to add “sources and types of” in the next to last bullet to avoid confusion that the best interest standard of conduct requires the discussion of actual compensation. She said the FACC also requests replacing the word “justification” with “basis” in the last bullet to mirror the revised model’s language because the FACC believes there is a legal distinction between the two words. The Working Group took the suggestions under advisement.

Mr. Birnbaum suggested that the Working Group consider adding language to the FAQ guidance document that would illustrate the differences between the revised model’s best interest standard of conduct and the prior model’s suitability standard. The Working Group took this suggestion under advisement.

The Working Group next discussed Question 5, which discusses what types of recommendations fall under the best interest standard of conduct. Ms. O’Brien said the FACC requests additional language to clarify that insurers are only expected to supervise recommendations that result in an application being submitted to the insurer. The Working Group took this suggestion under advisement.

The Working Group next discussed Question 6, which concerns the application of the best interest standard of conduct to a producer who never meets the client but assists a producer in making a recommendation to that client. The Joint Trades and the FACC submitted comments. Mr. Berkowitz said the Joint Trades suggest revisions to this question to provide additional context and clarity related to the provision’s intent. He referenced the revisions related to the meaning of “direct compensation” as an example. Ms. O’Brien said the FACC suggests revisions to clarify the meaning of “material control and influence” because the FACC believes the term is ambiguous. She said the FACC also recommends that the question explicitly state that a producer exercising material control or influence is not required to provide a disclosure notice to the client because such a requirement could create unnecessary confusion. Mr. Birnbaum said the CEJ has concerns about the way the question is written. He suggested rewriting the question to highlight the circumstances when certain requirements of the best interest standard of conduct would not apply.

The Working Group next discussed Question 7, which describes the provisions of Section 6A(1)(c) of the revised model requiring producers to be held to standards applicable to other producers with similar authority and licensure. The FACC suggests revisions to align the language more closely with the revised model’s language. The Joint Trades suggest clarifying language. The Working Group took the suggested revisions under advisement.

The Working Group next discussed Question 8. Question 8 describes how a producer or insurer can use the “Insurance Agent (Producer) Disclosure for Annuities” form to satisfy the disclosure obligation. The Joint Trades and the FACC submitted comments. Mr. Berkowitz said the Joint Trades suggest changes to make the question more understandable. He said the Joint Trades also suggest deleting the word “yes” because the Joint Trades believe the answer is not absolute and is more nuanced. Mr. Gendron expressed support for removing the word “yes.” Mr. Berkowitz said the Joint Trades also suggest adding a question to clarify how the disclosure obligation applies to producers relying on the safe harbor in Section 6E of the revised model, particularly with respect to completing the “Insurance Agent (Producer) Disclosure for Annuities” form to satisfy the disclosure obligation. Ms. O’Brien said the FACC suggests several revisions and additional questions related to the “Insurance Agent (Producer) Disclosure for Annuities” form intended to clarify whether this form is a relationship document or a transactional document. The Working Group took the suggested revisions under advisement.

The Working Group next discussed Question 9. Question 9 describes Section 5I(2) of the revised model concerning the definition of “material conflict of interest.” The Joint Trades and the FACC provided comments. Mr. Berkowitz said the Joint Trades struggled with this proposed question and proposed answer. He said the Joint Trades’ suggested revisions revise the proposed answer to more closely align with the question and the Model #275 revisions. The Joint Trades also suggest additional examples of what could be considered a material conflict of interest. The Working Group discussed the suggested revisions and the proposed examples. Ms. O’Brien said the FACC supports the Joint Trades’ comments. However, the FACC would
have concerns with adding the example concerning a producer acting as an attorney for the client and any other similar examples, such as a financial advisor acting as an accountant for the client because of concerns about how an insurer would supervise such conduct. The Working Group discussed the FACC’s concerns regarding the potential additional examples the Joint Trades suggest and the FACC’s potential additional examples. The Working Group also discussed how an insurer could possibly supervise producer compliance.

Duane Thompson (XY Planning Network) discussed the XY Planning Network’s comments on this issue and other issues previously discussed and its support for additional clarity to this question, particularly for dual registrants. The Working Group discussed whether there should be separate questions included in the FAQ guidance document for dual registrants. Mr. Berkowitz suggested that the Working Group keep in mind that the FAQ guidance document concerns obligations imposed under the revised model that relate to the conduct of a financial professional as an insurance producer. As such, any conduct that such a producer engages in as a state licensed investment advisor most likely falls outside the scope of the FAQ guidance document. However, Mr. Berkowitz noted that there are most likely issues that could be addressed in the FAQ guidance document related to dual registrants to ensure that they are providing the appropriate information to consumers, but this question may not be the appropriate place to include such language.

The Working Group deferred discussion of Question 10, which discusses how a producer could satisfy the conflict of interest obligation required under Section 6A(3). No comments were received on Question 11.

The Working Group next discussed the comments received on Question 12, which describes the provisions of Section 6C(2)(h). The Joint Trades and the FACC submitted comments. Ms. O’Brien said the FACC would appreciate any additional clarity on sales contests with respect to Section 6C(2)(h).

The Working Group next discussed the Joint Trades’ suggestion to add a new question concerning the revised model’s safe harbor provision. The proposed new question concerns whether insurers and producers in compliance with rules imposed by other regulators that meet or exceed the requirements in the revised model must comply with the revised model’s requirements. Mr. Berkowitz said the Joint Trades suggest adding this question to clarify the Working Group’s intent related to the safe harbor provision. Mr. Bissett suggested that the Working Group provide more clarity on what specific provisions in the revised model still apply to financial professionals that fall under the safe harbor provision. The Working Group took the suggestions under advisement, recognizing the complexity of the regulatory scheme and the difficulty of reflecting that in a FAQ guidance document.

The Working Group next discussed the comments received related to the revised model’s training requirements. The new training requirements require producers, who have already completed the existing training requirements prior to a state’s effective date of adoption of the revised model within six months after that effective date, to complete either a four-credit training course or an additional one-credit training course on the appropriate sales practices, replacement and disclosure requirements under the revised model. NAIC staff incorporated those comments into a chart (Attachment Two-B3) that was distributed prior to the meeting.

Mr. Berkowitz discussed the Joint Trades’ comments and suggested revisions, which reflect discussions with the states that have already adopted the revised model. He explained that the Joint Trades’ suggested revisions, including additional questions on the topic, reflect their interpretation of the revised model’s training provisions. He said the Joint Trades believe it is critical to get clarity on these issues to ensure consistent interpretation and application amongst the states as they move forward with adopting the revised model. He discussed some of the issues, including the difference between the one-credit training versus the four-credit training, when it is appropriate for a producer to take the one-credit training versus the four-credit training, and any implications with respect to state reciprocity. He also discussed one state’s interpretation of the six-month grace period that appears to be contrary to the Working Group’s intent.

Mr. Sanders said the NAIFA also submitted comments on the training requirement and suggested revisions to the FAQ guidance document that it also received from the states and producers. Mr. Bissett expressed concern with the Joint Trades’ suggested revision that suggest that a financial professional using the safe harbor provision is not required to complete the four-credit training or the one-credit training. He said this would create an unlevel playing field. Commissioner Ommen asked Mr. Bissett if his concerns remained if the financial professional is in compliance with comparable standards, including the content of such standards. Mr. Bissett said in theory, it could address his concerns, but such comparable standards, including content, may not address specific annuity provisions in the revised model.
Mr. Berkowitz said the Joint Trades believe their suggested additional question and the other questions related to the safe harbor provision reflect their belief that, in including the safe harbor provision, the Working Group implicitly recognized that the provisions of the revised model as compared to the components and specific requirements from other comparable standards would be roughly equivalent, including those provisions related to the training requirement. He questioned the value of the safe harbor provision if financial professionals relying on comparable standards are required to comply with specific provisions in the revised model. He also noted that if an insurance commissioner determines that a producer has failed to comply with the requirements of the comparable standard that the producer is relying on for compliance with the revision model, the insurance commissioner can hold the producer responsible for compliance with the revised model’s provisions. Commissioner Ommen pointed out that in some respects, the Working Group is working in the dark with respect to the safe harbor provision, particularly with respect to the U.S. Securities and Exchange Commission’s (SEC’s) best interest regulation because the SEC is not that far ahead of the states in implementing its regulation. As such, it is hard to know what is comparable because the Working Group does not have that information yet.

Commissioner Ommen said as next steps, he believes that the Working Group should hold a regulator-to-regulator call to discuss any revisions to the FAQ guidance document based on the discussion during this meeting. There was no objection to this suggestion.

Having no further business, the Annuity Suitability (A) Working Group adjourned.
**SUITABILITY IN ANNUITY TRANSACTIONS MODEL REGULATION (#275)**

**BEST INTEREST STANDARD OF CONDUCT REVISIONS**

**FREQUENTLY ASKED QUESTIONS**

This Frequently Asked Questions (FAQ) document is intended to specifically address those questions that are likely to arise as the states work to adopt the revised *Suitability in Annuity Transactions Model Regulation (#275)* and to assist in the uniform implementation and enforcement of its provisions across all NAIC member jurisdictions. No provision of this FAQ document is intended to supersede the specific language in Model #275.

This FAQ document is offered to any state that chooses to use it. It is not intended to expand the content of the model regulation but provides interpretive guidance regarding certain aspects of its provisions.

**GENERAL**

**Q1.** Why did the NAIC decide to revise the model to include a best interest standard of conduct?

**A1.** The revised model was developed, in part, in response to the U.S. Department of Labor’s (DOL) fiduciary rule, which was finalized in April 2016 but vacated in its entirety in March 2018. The DOL fiduciary rule would have expanded the scope of who is considered a fiduciary to federal Employee Retirement Income Security Act of 1974 (ERISA) retirement plans and individual retirement accounts (IRAs) to include a broader set of insurance agents, insurance brokers and insurers. Separately, the U.S. Securities and Exchange Commission (SEC) released a proposed rule package in May 2018, which included Regulation Best Interest (Reg BI). The SEC finalized Reg BI in June 2019. The final Reg BI establishes a best interest standard of conduct for broker-dealers beyond the existing suitability obligation that applies to federally registered variable annuities. Recognizing the SEC’s and the DOL’s role in the regulatory landscape and believing that consumers are better protected when, to the extent possible, there is harmonization of the regulations enforced by the states, the SEC and the DOL, the NAIC revised the model to establish a framework for an enhanced standard of conduct that is more than the model’s current suitability standard but not a fiduciary standard.

**Q2.** How does the Harkin amendment, Section 989J of the Dodd-Frank Act apply to the revised model?

**A2.** Section 989J confirms state authority to regulate the sale of fixed indexed annuities and exemption from federal securities regulation when certain conditions are met, including when the state in which the contract is issued or the state in which the insurer issuing the contract is domiciled:1) has adopted requirements that “substantially meet or exceed the minimum requirements” established by the 2010 version of the NAIC’s *Suitability in Annuity Transactions Model Regulation (#275)*; and 2) “adopts rules that substantially meet or exceed the minimum requirements of any successor modifications to the model regulation[ ]” within 5 years of the adoption by the NAIC. The only exception to this requirement is if the product is issued by an insurance company that adopts and implements practices on a nationwide basis that meet or exceed the minimum requirements established by the NAIC’s Model #275, “and any successor thereto,” and is therefore subject to examination by the State of domicile or by any other State where the insurance company conducts sales of such products.

The NAIC considers the 2020 revisions to be a successor modification to the model that exceeds the requirements of the 2010 revisions, which is reflected in a drafting note to Section 1—Purpose:

“Section 989J of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (‘Dodd-Frank Act’) specifically refers to this model regulation as the ‘Suitability in Annuity Transactions Model Regulation.’ Section 989J of the Dodd-Frank Act confirmed this exemption of certain annuities from the Securities Act of 1933 and confirmed state regulatory authority. This regulation is a successor regulation that exceeds the requirements of the 2010 model regulation.”

As such, states need to work toward adopting the 2020 revisions within 5 years after its adoption by the full NAIC membership in February 2020 to maintain their authority to regulate the sale of fixed annuities.
EXEMPTIONS

Q3. What is the intent of the exemption to the revised model’s provisions under Section 4A to allow a consumer in response to a direct response solicitation to purchase an annuity product where no recommendation is made based on information collected from the consumer?

A3. This exception from the rule was in the 2010 model rule and was not changed in the 2020 version. A direct-response solicitation is a solicitation through a sponsoring or endorsing entity solely through mails, the Internet, a digital platform, or other mass communication media that does not involve a communication directed to a specific individual by a natural person, or by a simulated human voice.

BEST INTEREST STANDARD OF CONDUCT

Q4. What is the best interest standard of conduct and how would a producer or insurer satisfy it?

A4. To satisfy the best interest obligation, a producer or an insurer must satisfy the four obligations: 1) care; 2) disclosure; 3) conflict of interest; and 4) documentation.

To satisfy the four obligations, when making a recommendation, producers must:
- Know the consumer’s financial situation, insurance needs and financial objectives;
- Understand the available recommendation options;
- Have a reasonable basis to believe the recommended option effectively addresses the consumer’s financial situation, insurance needs and financial objectives;
- Communicate the basis of the recommendation to the consumer;
- Disclose their role in the transaction, their compensation, and any material conflicts of interest; and
- Document, in writing, any recommendation and the justification for such recommendation.

Q5. What types of recommendations fall under the best interest standard of conduct?

A5. All recommendations made by a producer or insurer to purchase, exchange or replace an annuity product must comply with the best interest standard of conduct. Specifically, as defined in Section 5M, a “recommendation” is advice provided by a producer to an individual consumer that was intended to result or does result in a purchase, an exchange or a replacement of an annuity in accordance with that advice. A recommendation does not include general communication to the public, generalized customer services assistance or administrative support, general educational information and tools, prospectuses, or other product and sales material.

Q6. Does the best interest standard of conduct apply to a producer who never meets the client, but assists a producer in making a recommendation to the client?

A6. Yes, under Section 6A(5), a producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, regardless of whether the producer has had any direct contact with the consumer.

CARE OBLIGATION

Q7. What is the intent of language in Section 6A(1)(c), which states “Producers shall be held to standards applicable to producers with similar authority and licensure?”

A7. The intent of this language is to help to ensure that in any compliance or enforcement action, a producer’s recommendation is compared only to other producers as opposed to being compared to investment advisers or possibly
higher-level fiduciaries, such as trust officers or plan sponsors under the federal Employee Retirement Income Security Act of 1974 (ERISA) for compliance and enforcement purposes.

**DISCLOSURE OBLIGATION**

Q8. To satisfy the disclosure obligation, Section 6A(2)(a) requires a producer to provide the completed “Insurance Agent (Producer) Disclosure for Annuities” form in Appendix A prior to a recommendation, can a producer provide the form at the initial client meeting? Is the producer required to update the form and provide it again or can the producer provide it once and satisfy this obligation?

A8. Yes, a producer can satisfy the disclosure obligation by providing a completed form during the initial client meeting. However, if, after the completed form is provided to the client, the information on the completed form becomes out-of-date prior to a recommendation, the producer is expected to provide the consumer with an updated form.

**CONFLICT OF INTEREST OBLIGATION**

Q9. As defined in Section 5I(2), a material conflict of interest does not include cash compensation or non-cash compensation, what other type of financial interest would be considered a material conflict of interest? Is it only an ownership interest as referenced in Section 6A(3)?

A9. A producer who is also dually registered as an investment advisor under state securities law is required under Section 6A(3) to reasonably manage and disclose the related conflicts of interest. This management must commence when the producer first meets with a potential customer even before the dually licensed producer knows the ultimate capacity in which the producer will be acting. The actual capacity when the producer executes a specific transaction may not be known early in the relationship and the related professional or contractual obligations may not be determined based upon the specific facts and circumstances and the consumer profile information until later in the relationship, thus creating a conflict of interest for the producer. The dually licensed producer should assume that both Model #275 and the Investment Advisers Act apply, and that the producer must manage and disclose the conflict of interest.

Q10. Under Section 6A(3), to satisfy the conflict of interest obligation, what must a producer do to identify and avoid or reasonably manage a material conflict of interest? Examples?

A10. The differences in professional and contractual obligations between a producer acting in the consumer's best interest at the time of the transaction and an investment advisor acting in the consumer's best interest over the term of a professional advisory contract are substantial. Managing this conflict of interest will require more than simple disclosure. The dually licensed producer must ensure that the customer has a timely comprehension of the producer's varied interests in the relationship decisions and the producer must ultimately and before making a recommendation have a reasonable basis to believe the producer's recommended professional relationship or capacity along with any related annuity recommendation effectively addresses the consumer's financial situation, insurance needs and financial objectives.

**SUPERVISION SYSTEM**

Q11. Do these revisions require insurers to set up new supervision systems to ensure producer compliance with this new standard of conduct?

A11. No, but the revisions do add additional insurer supervision requirements by requiring insurers to establish and maintain reasonable procedures in three additional areas:

- To assess whether a producer has provided to the consumer the information required by the revised model.
- To identify and address suspicious consumer refusals to provide consumer profile information.
- To identify and eliminate any sales contests, sales quotas, bonuses, and non-cash compensation that are based on the sales of specific annuities within a limited period of time.
Q12. Section 6C(2)(h) requires an insurer as part of its supervision system to identify and eliminate sales contests, quotas, bonuses, and non-cash compensation based on the sale of specific annuities within a limited period of time. What type of business practices is provision intended to address?

A12. The requirements of Section 6C(2)(h) are not intended to prohibit general incentives regarding sales of an insurance company’s products where there is no emphasis on a particular product. As the provisions states, insurer business practices involving sales contests, quotas, bonuses and non-cash compensation based on the sale of a specific annuity or annuities within a specified or limited period of time are prohibited and should be identified and eliminated.

TRAINING

Q13. Do producers complete additional training on the new standard of conduct even if they have already completed the existing annuity training requirements?

A13. Yes, Section 7 requires a producer who has already completed the existing annuity training requirements prior to a state’s effective date of the revised model to complete within 6 months of that date either a four credit training course or an additional one-time one credit training course on the appropriate sales practices, replacement and disclosure requirements under the revised model. In adopting this section, a state could choose a different timeframe for this requirement.
## GENERAL

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The NAIC considers the 2020 revisions to be a successor modification to the model that exceeds the requirements of the 2010 revisions, which is reflected in a drafting note to Section 1—Purpose:

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As such, states need to work toward adopting the 2020 revisions within 5 years after its adoption by the full NAIC membership in February 2020 to maintain their authority to regulate the sale of fixed annuities.

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1 Joint submission from the American Council of Life Insurers (ACLI), the Committee of Annuity Insurers (CAI), the Financial Services Institute (FSI), the Indexed Annuity Leadership Council (IALC), the Insured Retirement Institute (IRI) and the National Association for Fixed Annuities (NAFA).
A2. Section 989J confirms state authority to regulate the sale of fixed and fixed indexed annuities and provides an exemption for such annuities from federal securities regulation when certain conditions are met, including when the state in which the contract is issued or the state in which the insurer issuing the contract is domiciled: 1) has adopted requirements that “substantially meet or exceed the minimum requirements” established by the 2010 version of the NAIC’s Suitability in Annuity Transactions Model Regulation (#275); and 2) “adopts rules that substantially meet or exceed the minimum requirements of any successor modifications to the model regulation[1]” within 5 years of the adoption by the NAIC. The only exception to this requirement is if the product is issued by an insurance company that adopts and implements practices on a nationwide basis that meet or exceed the minimum requirements established by the NAIC’s Model #275, “and any successor thereto,” and is therefore subject to examination by the State of domicile or by any other State where the insurance company conducts sales of such products.

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As such, states need to work toward adopting the 2020 revisions within 5 years after its adoption by the full NAIC membership in February 2020 to maintain the status of fixed and fixed indexed annuities meeting the requirements of Section 989J as outside the scope of federal securities regulation.

**NEW QUESTION**

**Joint Trades**

**Q2. How did the NAIC develop and promulgate these revisions to the model?**

A2. The NAIC had a robust, collaborative and transparent process that included a wide array of stakeholders through the drafting and vetting processes. The NAIC’s Annuity Suitability (A) Working Group completed the revisions to the model with the input of consumer groups, regulators, academics, and industry trade associations in open deliberations. Ultimately, the revised model is a work product that will provide enhanced consumer protections and amend regulation of annuity transactions in a sensible way.

**EXEMPTIONS**
### Q3. What is the intent of the exemption to the revised model’s provisions under Section 4A to allow a consumer in response to a direct response solicitation to purchase an annuity product where no recommendation is made based on information collected from the consumer?

A3. This exception from the rule was in the 2010 model rule and was not changed in the 2020 version. A direct-response solicitation is a solicitation through a sponsoring or endorsing entity solely through mails, the Internet, a digital platform, or other mass communication media that does not involve a communication directed to a specific individual by a natural person, or by a simulated human voice.

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### BEST INTEREST STANDARD OF CONDUCT

### Q4. What is the best interest standard of conduct and how would a producer or insurer satisfy it?

A4. To satisfy the best interest obligation, a producer or an insurer must satisfy the four obligations: 1) care; 2) disclosure; 3) conflict of interest; and 4) documentation.

To satisfy the four obligations, when making a recommendation, producers must:
- Know the consumer’s financial situation, insurance needs and financial objectives;
- Understand the available recommendation options;
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### Q6. Does the best interest standard of conduct apply to a producer who never meets the client, but assists a producer in making a recommendation to the client?

#### Joint Trades

A6. Yes, under Section 6A(5), a producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, regardless of whether the producer has had any direct contact with the consumer.

#### FACC

A6. Yes, under Section 6A(5), a producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, has an obligation to comply with the revised model's best interest standard regardless of whether the producer has had any direct contact with the consumer. Compensation tied to overall sales volume of a firm or a producer would not be considered “direct compensation” for purposes of this section. A producer will not be treated as having exercised material control or influence merely because the producer provides or delivers marketing or educational materials, product wholesaling or other back office product support, or general supervision of another producer.

### CARE OBLIGATION

### Q7. What is the intent of language in Section 6A(1)(c), which states “Producers shall be held to standards applicable to producers with similar authority and licensure?”

#### Joint Trades

A7. The intent of this language is to help to ensure that in any compliance or enforcement action, a producer’s recommendation is compared only to other producers as opposed to being compared to investment advisers or possibly higher-level fiduciaries, such as trust officers or plan sponsors under the federal Employee Retirement Income Security Act of 1974 (ERISA) for compliance and enforcement purposes.
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**DISCLOSURE OBLIGATION**

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<th>Q8.</th>
<th>To satisfy the disclosure obligation, Section 6A(2)(a) requires a producer to provide the completed “Insurance Agent (Producer) Disclosure for Annuities” form in Appendix A prior to a recommendation, can a producer provide the form at the initial client meeting? Is the producer required to update the form and provide it again or can the producer provide it once and satisfy this obligation?</th>
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<td>A8.</td>
<td>Yes, a producer can satisfy the disclosure obligation by providing a completed form during the initial client meeting. However, if, after the completed form is provided to the client, the information on the completed form becomes out-of-date prior to a recommendation, the producer is expected to provide the consumer with an updated form.</td>
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Q. Do producers who are relying on the safe harbor in Section 6E have to provide the completed “Insurance Agent (Producer) Disclosure for Annuities” form in Appendix A?
A. No, a producer operating in compliance with business rules, controls and procedures that satisfy a “comparable standard” (as defined under the revised model) is not required to also provide disclosure on the form in Appendix A. Under such circumstances, the producer need only comply with the disclosure requirements imposed under the applicable comparable standard (e.g., the disclosures contemplated by Reg BI and Form CRS).

FACC

Q8. To satisfy the disclosure obligation, Section 6A(2)(a) requires a producer to provide the completed “Insurance Agent (Producer) Disclosure for Annuities” form in Appendix A prior to a recommendation, can a producer provide the form at the initial client meeting? Is the producer required to update the form and provide it again or can the producer provide it once and satisfy this obligation?

A8. A producer can satisfy the disclosure obligation by providing the completed form during the initial client meeting or at any time prior to the recommendation or sale. A separate completed form must be provided by the producer to the client for each recommendation or sale. A form substantially similar to Appendix A is deemed to satisfy the requirements set forth in Section 6A((2)(a). If, after the completed form is provided to the client, the information on the completed form becomes out-of-date prior to a recommendation or sale, the producer is expected to provide the consumer with an updated form prior to consummation of the transaction. For purposes of supervision, insurers may accept attestation from the producer that the completed form was presented to the client, and insurers are not responsible for content of the completed disclosure form except to the extent it applies to the relationship between the insurer and the producer or products offered by the insurer.

Q8a. On the Appendix A disclosure form where it asks “whose annuities can I sell to you,” how should producers differentiate between “two or more” and “two or more although I primarily sell annuities from” a specific insurer in cases where the producer sells mostly for one insurer but is not required to do so by contract?

A8a. When answering the question “whose annuities can I sell to you”, the response “two or more” is appropriate rather than “two or more although I primarily sell annuities from” a specific insurer if the agent has no contractual obligation to work exclusively or semi-exclusively with a single company or family of companies. The fact that an agent sells products mostly for a certain insurer in a given time period, absent a contractual obligation, should not affect how that item is completed on the disclosure form.

Q8b. For the Appendix A disclosure form section titled “How I’m Paid for My Work,” does that only apply to cash compensation paid to the producer for sale of the annuity that is being recommended, as opposed to any compensation paid to the producer for other kinds of financial services.

Q8b. Yes, the producer is expected to disclose information on the form concerning compensation paid to the producer that is directly related to purchase of the annuity which in most cases will either be commission paid by the insurance company or fees paid by the consumer in the case of fee-based annuities. However, to the extent the agent provides any other kinds of services (for example, investment advice, accounting, tax consulting, legal services), compensation for such services are not required to be disclosed on this form if unrelated to purchase of the annuity though in most cases other laws and regulations will require separate disclosure of such compensation and agreement to the same by the consumer.
Q8c. Is it permissible for a producer to use the Appendix A disclosure form to disclose any material conflicts of interest?

Q8c. Yes, producers are required to make disclosures required by the regulation using a form substantially similar to Appendix A. This means producers may modify the form to include additional information disclosing material conflicts of interest as required by Section 6(A)(3), or absence of any such conflicts, provided the additional information does not interfere with presentation of the required information described in Section 6(A)(2).

CONFLICT OF INTEREST OBLIGATION

Q9. As defined in Section 5I(2), a material conflict of interest does not include cash compensation or non-cash compensation, what other type of financial interest would be considered a material conflict of interest? Is it only an ownership interest as referenced in Section 6A(3)?

A9. A producer who is also dually registered as an investment advisor under state securities law is required under Section 6A(3) to reasonably manage and disclose the related conflicts of interest. This management must commence when the producer first meets with a potential customer even before the dually licensed producer knows the ultimate capacity in which the producer will be acting. The actual capacity when the producer executes a specific transaction may not be known early in the relationship and the related professional or contractual obligations may not be determined based upon the specific facts and circumstances and the consumer profile information until later in the relationship, thus creating a conflict of interest for the producer. The dually licensed producer should assume that both Model #275 and the Investment Advisers Act apply, and that the producer must manage and disclose the conflict of interest.

Joint Trades

Q9. As defined in Section 5I(2), a material conflict of interest does not include cash compensation or non-cash compensation. What other type of financial interest would be considered a material conflict of interest? Is it only an ownership interest as referenced in Section 6A(3)?

A9. The revised model defines material conflict of interest as “a financial interest of the producer in the sale of an annuity that a reasonable person would expect to influence the impartiality of a recommendation.” Cash and non-cash compensation are not considered to be material conflicts of interest, though the revised model does require disclosure about producer compensation and impose restrictions on certain types of non-cash compensation, as described in Q14/A14 below. An ownership interest (such as where a producer has a material ownership interest in an insurance company whose products the producer is authorized to recommend) is one example of a material conflict of interest that would be subject to the revised model’s conflict of interest obligation. Depending on the particular facts and circumstances, a producer could also be deemed to have a material conflict of interest if, for example, he or she, while acting as a producer: 1) Makes a personal loan of money or securities to a customer, or accepts such a loan from a customer; or 2) Acts as an attorney for the same customer.

FACC

Q9. As defined in Section 5I(2), a material conflict of interest does not include cash compensation or non-cash compensation. What other type of financial interest would be considered a material conflict of interest? Is it only an ownership interest as referenced in Section 6A(3)?
A9. The revised model defines material conflict of interest as “a financial interest of the producer in the sale of an annuity that a reasonable person would expect to influence the impartiality of a recommendation.” As stated in the model regulation, material conflict of interest could include ownership interest in the insurance company issuing the recommended annuity if that ownership interest is significant enough that a reasonable person would expect it to influence the producer’s impartiality in comparing annuity product options. Ownership interest is mentioned in the model regulation as an example and is not exclusive. Depending on facts and circumstances, other examples would include situations where a producer or the producer’s agency has borrowed funds from an insurance company or the producer’s relative such as spouse/partner or parent holds an executive position at an insurance company if in those situations a reasonable person would expect the producer’s impartiality to be affected when making a recommendation of an annuity.

Q10. Under Section 6A(3), to satisfy the conflict of interest obligation, what must a producer do to identify and avoid or reasonably manage a material conflict of interest? Examples?

A10. The differences in professional and contractual obligations between a producer acting in the consumer’s best interest at the time of the transaction and an investment advisor acting in the consumer’s best interest over the term of a professional advisory contract are substantial. Managing this conflict of interest will require more than simple disclosure. The dually licensed producer must ensure that the customer has a timely comprehension of the producer’s varied interests in the relationship decisions and the producer must ultimately and before making a recommendation have a reasonable basis to believe the producer’s recommended professional relationship or capacity along with any related annuity recommendation effectively addresses the consumer’s financial situation, insurance needs and financial objectives.

Joint Trades

Q10. Under Section 6A(3), to satisfy the conflict of interest obligation, what must a producer do to identify and avoid or reasonably manage and disclose a material conflict of interest? Examples?

A10. The appropriate steps to satisfy the obligation to identify and avoid or reasonably manage and disclose material conflicts of interest will depend on the specific facts and circumstances. In some cases, material conflicts of interest can be effectively managed by a producer by informing his or her client of the conflict, and answering any questions the client may have regarding the conflict and confirming that the client is willing to continue working with the producer. In other instances, informed disclosure alone may be insufficient and the producer will have to take additional steps to ensure that the conflict does not cause the producer to make a recommendation that is not in the client’s best interest or that puts the producer’s own financial interests ahead of the client’s. In such instances, a producer could, for example, consult with his or her manager, supervisor or agency principal to assess whether a conflict is inappropriately influencing the impartiality of the producer’s recommendations. Finally, there may be material conflicts of interest that cannot be effectively mitigated through informed disclosure and additional measures. In those situations, the producer would have to avoid engaging in the activity or relationship that would give rise to the conflict, or, alternatively, abstain from making the recommendation. In all cases, the producer must ultimately and before making a recommendation have a reasonable basis to believe the producer’s professional relationship or capacity along with any related annuity recommendation effectively addresses the consumer’s financial situation, insurance needs and financial objectives.
**FACC**

**Q10.** Under Section 6A(3), to satisfy the conflict of interest obligation, what must a producer do to identify and avoid or reasonably manage and disclose a material conflict of interest? Examples?

**A10.**

As noted above, a material conflict of interest for purposes of the model regulation means a “financial interest of the producer in the sale of an annuity that a reasonable person would expect to influence the impartiality of a recommendation.” The regulation is concerned with whether the producer is motivated by financial interests other than compensation in recommending one annuity over another that may conflict with the interests of the client. In all cases, the producer must identify such conflicts, and if they exist, the producer must either avoid the conflict or disclose and reasonably manage the conflict. For example, if the producer’s agency has borrowed money from an insurance company, the producer must identify whether that debt obligation rises to a material conflict of interest, and if it does, the producer must either avoid the conflict by refraining from recommending annuities issued by that insurer, or disclosing the conflict to the consumer and taking steps to ensure recommendations of an annuity issued by that insurance company would effectively address the needs and objectives of the consumer in accordance with the model regulation. It should be noted here that a producer who is also an investment advisor, lawyer, CPA, or other kind of professional who “wears more than one hat” would not have a material conflict of interest based solely on the fact the producer serves in that dual capacity based on the definition of material conflict of interest in this regulation but may have a conflict of interest under protocols pertaining to those other professions. From an insurance regulatory perspective, the obligation of the producer is to disclose that he or she is in the business of selling annuities and compensated for such sales which is accomplished by compliance with the disclosure obligation under Section 6(A)(2).

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**SUPERVISION SYSTEM**

**Q11.** Do these revisions require insurers to set up new supervision systems to ensure producer compliance with this new standard of conduct?

**A11.** No, but the revisions do add additional insurer supervision requirements by requiring insurers to establish and maintain reasonable procedures in three additional areas:

- To assess whether a producer has provided to the consumer the information required by the revised model.
- To identify and address suspicious consumer refusals to provide consumer profile information.
- To identify and eliminate any sales contests, sales quotas, bonuses, and non-cash compensation that are based on the sales of specific annuities within a limited period of time.

**No comments received**

**Q12.** Section 6C(2)(h) requires an insurer as part of its supervision system to identify and eliminate sales contests, quotas, bonuses, and non-cash compensation based on the sale of specific annuities within a limited period of time. What type of business practices is provision intended to address?
A12. The requirements of Section 6C(2)(h) are not intended to prohibit general incentives regarding sales of an insurance company’s products where there is no emphasis on a particular product. As the provisions states, insurer business practices involving sales contests, quotas, bonuses and non-cash compensation based on the sale of a specific annuity or annuities within a specified or limited period of time are prohibited and should be identified and eliminated.

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<td>A12. The requirements of Section 6C(2)(h) are intended to prohibit sales contests, quotas, bonuses and non-cash compensation based on the sale of a particular product within a limited period of time. It is not intended to prohibit an insurance company from providing general incentives to producers with no emphasis on any particular product. The purpose of this provision is to prevent short-term targeted incentives that put undue pressure on producers to sell particular annuities in a manner that could be contrary to the best interest of the consumer. In general, this means incentives that reward sale of a particular annuity product (identified commonly by a product name) over a shorter period of time (for example a month or a quarter) should be identified and eliminated, because they put undue pressure on the producer to promote that product over other annuities that may more effectively address the consumer’s needs and objectives.</td>
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<th><strong>NEW SECTION – SAFE HARBOR</strong></th>
<th>Q15. Are insurers and producers required to comply with the requirements of the revised model if they are acting in compliance with rules imposed by other regulators that meet or exceed the requirements of the revised model?</th>
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<td>A15. No, Section 6E provides a safe harbor for recommendations and sales of annuities made by financial professionals in compliance with business rules, controls and procedures that satisfy “comparable standards” (as defined in the revised model), such as the best</td>
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interest standard under Reg BI, the fiduciary standard applicable to federally regulated investment advisers under the Investment Advisers Act of 1940, or the fiduciary standard imposed under ERISA. Under such circumstances, producers and insurers need not comply with any of the specific requirements included in the revised model, including the care, disclosure, conflict of interest, and documentation obligations, as well as the insurer supervision and producer training requirements. However, insurers do have important supervisory obligations with respect to annuity recommendations made by financial professionals relying on the safe harbor:

- Section 6E(2) specifies that, even where the safe harbor applies, insurers remain subject to the obligation under Section 6C(1) to “not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity would effectively address the particular consumer’s financial situation, insurance needs and financial objectives based on the consumer’s consumer profile information.”
- Section 6E(3) provides that an insurer must monitor the conduct of the financial professional relying on the safe harbor or the entity responsible for supervising the financial professional based on information collected in the normal course of the insurer’s business.
| **FREQUENTLY ASKED QUESTIONS IMPLEMENTATION DOCUMENT**  
Stakeholder Comments on Continuing Education/Training Requirements |
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<td><strong>Questions on Training Completed in a State Prior to State Adoption of the Revised Model</strong></td>
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| **Joint Trades**<sup>1</sup> | Q. Can producers satisfy their training obligations under the revised model by taking the new four credit training course or the new one credit training course before the revised model takes effect in a particular state?  
A. The revised model provides for reciprocity so producers that operate in multiple jurisdictions do not have to retake the same training multiple times. If a producer has completed a properly approved training course in a state where the revised model has been adopted (whether or not such revised model has become effective), the producer should not be required to complete the required training again in that same state after the effective date or in another state that subsequently adopts the revised model.  
Q. Can producers satisfy their training obligations under the prior version of the model in a state which has not yet adopted the revised model by taking the new four credit training course?  
A. The new four-credit training course includes all of the topics that were required to be covered under the prior version of the model (with information on the best interest standard of conduct now required under the revised model). As such, if a producer has completed a properly approved four credit training course in a state that has adopted the revised model, the producer should not be required to also complete a course that satisfies the requirements of the prior version of the model in a state that has not yet adopted the revised model. |
| **National Association of Insurance and Financial Advisors (NAIFA)** | Q. If a producer takes a new four credit and/or one credit training course—which complies with the requirements of Section 7 of the Amended Model and has been approved by the appropriate state authorities—prior to the effective date of a state’s amended annuity suitability regulation, would successful completion of that course i) count towards compliance with the state’s amended annuity suitability regulation once it becomes effective, and/or ii) count towards compliance with Section 7 B (9) of the Amended Model and be deemed to satisfy the training requirements of another state if/when that other state adopts the Amended Model?  
A. Yes—an approved training course taken prior to the effective date of a state’s amended regulation would count towards compliance with that state’s or another state’s amended regulation (including Section 7 B (9)) once it becomes effective.  
Q. If a producer takes an approved four credit training course in a state that has not adopted the Amended Model, would that producer be able to satisfy the training requirements in another state that has already adopted the Amended Model by taking the new one credit course specified in Section 7 B (6) (b) of the Amended Model? |

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<sup>1</sup> Joint submission from the American Council of Life Insurers (ACLI), the Committee of Annuity Insurers (CAI), the Financial Services Institute (FSI), the Indexed Annuity Leadership Council (IALC), the Insured Retirement Institute (IRI) and the National Association for Fixed Annuities (NAFA).
A. Yes—completing both the old four credit course—at any time—and the new one credit course is “substantially similar” to completing the new four credit course provided for in Section 7 of the Amended Model, and would comply with the requirements of Section 7 B (6) of the Amended Model.

Q. If a producer takes the new four credit training course in a state that has adopted the Amended Model, would that producer be deemed to have satisfied the training requirement of a state that has not adopted the Amended Model?

A. Yes—the new four credit training course provided for in the Amended Model is “substantially similar” to the four credit training course required under the prior version of Model #275, and would meet the requirements of Section 7 B (9) of the prior version of Model #275.

Questions on Training and the Safe Harbor

Q13. Do producers complete additional training on the new standard of conduct even if they have already completed the existing annuity training requirements?

A13. Yes, Section 7 requires a producer who has already completed the existing annuity training requirements prior to a state’s effective date of the revised model to complete within 6 months of that date either a four credit training course or an additional one-time one credit training course on the appropriate sales practices, replacement and disclosure requirements under the revised model. In adopting this section, a state could choose a different timeframe for this requirement.

Joint Trades

Q13. Do producers who are not relying on the safe harbor in Section 6E have to complete additional training on the new standard of conduct even if they have already completed the existing annuity training requirements?

A13. Yes, Section 7 requires a producer who has already completed the existing annuity training requirements prior to a state’s effective date of the revised model to complete within 6 months of that date either a four credit training course or an additional one-time one credit training course on the appropriate sales practices, replacement and disclosure requirements under the revised model.

Q. Are producers who are relying on the safe harbor required to complete the 4-hour training course (or, if eligible, the optional 1-hour training course), which includes training on the new standard of conduct under the revised model?

A. No. Producers relying on the safe harbor are not required to take the training prescribed by the revised model; the training required under the appropriate “comparable standards” (as defined in the revised model) will suffice. Insurers should, however, ensure that producers operating under the safe harbor have nonetheless completed appropriate training on the specific annuity products they are authorized to recommend and sell.
Questions about the One-Hour Training Requirement versus the Four-Hour Training Requirement

Joint Trades

Q. Under what circumstances would a producer be permitted to take the additional one credit training course rather than the full four credit training course? What is the difference between the one credit and four credit training courses? For how long should the one credit training course be available as an option?

A. The one credit training course is available as an option only to producers who have previously completed a four-credit training course that met the requirements of the prior version of the model. The four-credit training course would include information on all of the topics listed in Section 7B(3) of the revised model, whereas the one credit training course would include only information on the appropriate standard of conduct, sales practices, replacement and disclosure requirements. The one credit option was included in the revised model because the NAIC recognized that adoption of the revised model would not cause any changes in the information provided on the other topics covered by the four credit training course required under the prior version of the model.

The option to complete the one credit training course should be left available for as long as the prior version of the model remains in effect in any jurisdiction. This will ensure that producers who satisfy the training requirements in states where the prior version is still in effect would not have to retake the entire four credit training course, and can instead take the one credit training course to ensure that they understand how the rules have changed.

In sum, producers who are not relying on the safe harbor should be permitted to satisfy their training obligations by completing either (a) the four credit training course under the revised model OR (b) a combination of the four credit training course under the prior version of the model AND the one credit training course under the revised model.

The preceding applies to situations where a producer has taken an approved four credit training course in a state that has not adopted the amended NAIC Model and then seeks to satisfy the training requirement by taking the new one credit course in a state that has adopted the amended NAIC Model.

Failure to Timely Complete the Updated Four-Hour or One-Hour Training Course

Joint Trades

Q. Under Section 7B(6), if a producer who was already qualified by taking the old four credit training course fails to take the updated four credit training course or the one hour training course within six months after the effective date of the amended regulation, what training must a producer take to become requalified to offer annuities again?

A. A producer who does not timely meet the requirements to take the training courses but has already taken the old 4 credit training course may satisfy such new requirements by taking either the one credit or the four credit training course (which shall remain available) at any point after the expiration of the six month time period. The producer should cease all annuity sales activities until the updated training courses have been completed.
Draft Revisions to Industry Coalition’s Proposed FAQ on NAIC Best Interest Model Safe Harbor Provision

Q. Are producers required to comply with the specific requirements of the revised model if they are acting in compliance with rules imposed by other regulators that meet or exceed the requirements of the revised model?

A. Section 6E of the revised model provides a safe harbor for recommendations and sales of annuities made by producers who meet the definition of “financial professional” and operate in compliance with business rules, controls and procedures that satisfy “comparable standards.” For purposes of the safe harbor, comparable standards include the best interest standard under Reg BI, the fiduciary standard applicable to federally regulated investment advisers under the Investment Advisers Act of 1940, and the fiduciary standard imposed on providers of investment advice to retirement plans and participants under federal law. When making recommendations and sales of annuities in compliance with comparable standards, financial professionals need not comply with the specific requirements included in the revised model, such as the care, disclosure, conflict of interest, and documentation obligations set forth in Section 6A and, as discussed further below, the supervision requirements included in Section 6C(2) and the producer training requirements set forth in Section 7.

Reliance on the safe harbor does not remove an annuity transaction from insurance regulatory oversight. State insurance regulators retain their full authority to investigate and enforce the requirements of the revised model against any financial professional that fails to fully satisfy the requirements of the relevant comparable standard. In other words, a financial professional cannot use the safe harbor to avoid their obligations under the revised model by simply asserting that they are a financial professional operating under a comparable standard – actual compliance with the comparable standard is required. As a drafting note in the revised model clearly indicates, non-compliance with comparable standards results in a recommendation or sale being subject to the requirements of the model.

This provision was included in the revised model to avoid the imposition of differing or duplicative requirements on financial professionals as they endeavor to achieve and maintain full compliance with multiple overlapping regulations that are aligned in terms of application and public policy objectives but are not fully identical in terms of specific regulatory requirements. The safe harbor recognizes and acknowledges that consumers will receive no greater level of protection against improper conduct by requiring financial professionals to separately comply with the particular requirements of multiple regulations that are designed to achieve the same objectives but take different approaches that are tailored to the different segments of the financial services industry to which they apply.

Q. Who is responsible for supervision of recommendations and sales of annuities made in reliance on and compliance with a comparable standard under the safe harbor, and what are their supervisory obligations?

A. Under Section 6.C of the revised model, insurers are generally responsible for supervising the conduct of producers who recommend and sell the insurer’s annuities. However, the safe harbor recognizes that the comparable standards establish their own supervisory obligations that are carefully tailored to the types of transactions covered by those rules. As such, insurers are not required to supervise safe harbor transactions in the same ways as non-safe harbor transactions as long as the supervising entity is meeting its obligations to supervise for compliance with the comparable standard.

For example, the revised model places responsibility for supervision on insurers whereas Regulation Best Interest puts that obligation on broker-dealer firms. While this distinction is necessary and appropriate based on the differences between the insurance and securities industries, the end result is the same in both cases – a highly regulated entity is responsible for supervising the conduct of individuals who make recommendations to consumers.

The safe harbor does not, however, fully relieve insurers of supervisory responsibility with respect to financial professionals who comply with comparable standards when recommending and selling annuities. Insurers are subject to the following important supervisory obligations with respect to annuity recommendations made by financial professionals relying on the safe harbor:

- Section 6E(2) specifies that, even where the safe harbor applies, the insurer remains subject to the obligation under Section 6C(1) to “not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the
annuity would effectively address the particular consumer’s financial situation, insurance needs and financial objectives based on the consumer’s consumer profile information.”

- Section 6E(3) requires that the insurer monitor the conduct of the financial professional relying on the safe harbor or the entity responsible for supervising the financial professional based on information collected in the normal course of the insurer’s business and must provide the supervising entity any information and reports that are appropriate to assist such entity to maintain its supervision system.

However, just as a financial professional would lose the benefit of the safe harbor if she fails to actually comply with the relevant comparable standard, the insurer would have to satisfy the supervisory obligations in Section 6C of the revised model if the entity responsible for oversight of the financial professional fails to satisfy its supervisory responsibilities under the comparable standard.

This framework ensures proper alignment between the regulatory standard under which the financial professional is operating and the supervisory system implemented by the entity with primary responsibility for oversight. The supervisory system contemplated by Section 6C(2) of the revised model is designed to ensure compliance with Section 6A of the revised model and therefore would not necessarily be an effective mechanism by which to ensure compliance with the requirements of a comparable standard. If an insurer applies its Section 6C(2) system to supervise a financial professional operating under the safe harbor, that financial professional could potentially be flagged for noncompliance even if she is in full compliance with the comparable standard. The safe harbor’s approach to supervision is intentionally designed to avoid this problem.

Q. Are producers who are relying on the safe harbor required to complete the 4-hour training course (or, if eligible, the optional 1-hour training course), which includes training on the new standard of conduct under the revised model?

A. Producers relying on the safe harbor are not required to take the training prescribed by the revised model as long as they are properly trained under the relevant comparable standard. The training requirement under the revised model is intended to ensure that producers understand general annuity principles, the specific annuity products they can recommend to their clients, and the rules under which they are required to operate. A training program designed to meet the specific requirements of the revised model would not achieve this objective in the context of a producer relying on the safe harbor as it would not cover the rules under which producer is actually operating (because, as noted above, the requirements of comparable standards may not be fully identical to those established under the revised model). By covering the training provision, the safe harbor ensures that producers will be required to complete the right training for their specific circumstances.
Proposed Additions to the Frequently Asked Questions Implementation Document  
Submitted by IIABA / March 23, 2021

Q_. Must producers that rely on the safe harbor comply with the requirements that are established by the model?

A_. No. There are differences and distinctions between the obligations established under the model and the duties imposed by the “comparable standards” identified in Section 6(E)(5). The model in some ways applies more robust consumer protections upon producers that recommend annuities than the “comparable standards.” The model, for example, establishes a duty to make a written record of any recommendation and the basis for that recommendation, but Regulation Best Interest includes no analogous obligation. States that are concerned with establishing uniformity in annuity transactions (and the market conduct regulatory implications of not doing so) and applying consistent obligations on producers who make such recommendations may wish to consider narrowing the scope of the safe harbor and/or expressly applying certain elements of the model to those producers who seek to rely on it.

States that are concerned the safe harbor might inadvertently relieve producers of other important duties – such as obligations under Section 6(D) (related to prohibited practices), Section 8 (related to enforcement), and Section 9 (related to recordkeeping) – may wish to further narrow the application of the safe harbor and make clear that it only applies to the core requirements set forth in Section 6(A).

Q_. When may a broker-dealer or registered representative rely on the safe harbor?

A_. The definition of “comparable standards” in Section 6(E)(5) provides that broker-dealers and registered representatives may only rely on the safe harbor when they comply with “applicable SEC and FINRA rules pertaining to best interest obligations and supervision of annuity recommendations and sales” (emphasis added). In other words, broker-dealers and registered representatives may only take advantage of the safe harbor when a SEC or FINRA rule applies on its own to a particular annuity recommendation. The safe harbor is not limited to investment advisors and plan fiduciaries or fiduciaries in the same way.

Q_. Does the safe harbor exempt insurers from any of the supervisory or other requirements established by the model?

A_. No. The safe harbor applies to the recommendations and sales activities of certain producers, and, regardless of whether one of its producers relies on the safe harbor, insurers remain responsible for complying with the supervisory requirements of Section 6(C), the prohibitions of Section 6(D), the enforcement provisions of Section 8, and the recordkeeping obligations of Section 9. While insurers are ultimately responsible for a producer’s actions and compliance with the regulation, they are permitted to enter into arrangements and contracts with other parties for the performance of supervisory functions.

Q_. Are all producers who recommend annuities required to satisfy the training requirements of Section 7(B)?

A_. Yes. The safe harbor does not eliminate any producer’s obligation to satisfy the training requirements of Section 7(B). Those training requirements provide basic instruction on the issues and considerations that any person selling an annuity should know, such as the types and uses of annuities, how annuity contract features affect consumers, and tax implications. Any person seeking to take advantage of the safe harbor must be licensed as a producer and in good standing (which includes satisfying the training requirements of Section 7(B)) and be appointed by the insurer where and as required by state law.
Questions: The model regulation defines "material conflict of interest" as a financial interest of the producer that a reasonable person would expect to influence the impartiality of the recommendation. The model regulation also specifically excludes "cash and non-cash compensation" from the requirement for material conflicts of interest. Why did the NAIC determine that "cash and non-cash compensation" is excluded from the requirement to "identify and avoid or reasonably manage and disclose" material conflicts of interest?

**CEJ Proposed Answer:** The NAIC determined that most forms of routine compensation do not create a material conflict of interest and that most conflicts of interest that might be created by compensation arrangements can be addressed through the Insurance Agent (Producer) Disclosure of Annuities, required by the model regulation to be provided to the consumer and which includes a section “How I’m Paid for My Work.” The NAIC determined that general incentives regarding the sales of a company’s products with no emphasis on any particular product do not create a material conflict of interest. The NAIC identified some types of compensation arrangements that likely create a material conflict of interest and requires the insurer to identify and eliminate sales contests, sales quotas, bonuses and non-cash compensation based on sales of specific annuities within a limited time frame.

**Several States’ Proposed Answer:** The NAIC determined that most forms of producer compensation do not present a material conflict of interest with the purchaser, and that purchasers expect producers to be compensated. The revisions to Model #275 make it clear that annuity recommendations by producers must be in the best interest of the consumer, and that producers may not place the producer’s financial interest ahead of the consumer’s interest. Therefore, the NAIC determined that the requirement to “identify and avoid or reasonably manage and disclose” should not apply to “cash and non-cash compensation”. Rather, disclosure of the producer relationship and related compensation is the appropriate management requirement.

Under the new disclosure requirement producers must prominently disclose to a consumer certain information about cash compensation and non-cash compensation to be received by the producer, and must prominently notify the consumer of the right to additional cash compensation information. For clarity, the NAIC developed a model disclosure form (Appendix A) which includes a section “How I’m Paid for My Work.” Producers must disclose cash and non-cash compensation on Appendix A or a substantially similar form.

The NAIC also determined that general incentives regarding production levels with no emphasis on any particular product do not create an unanticipated conflict of interest requiring avoidance or management.

However, the NAIC did conclude that sales contests, sales quotas, bonuses and non-cash compensation based on sales of specific annuities within a limited time frame should be avoided. Accordingly, the Model #275 revisions require insurers to identify and eliminate these arrangements.
The Life Insurance Illustration Issues (A) Working Group of the Life Insurance and Annuities (A) Committee met March 10, 2021. The following Working Group members participated: Richard Wicka, Chair (WI); Chris Struk (FL); Teresa Winer (GA); and Jana Jarrett (OH). Also participating were: Denise Lamy (NH); Sarah Neil (RI); John Carter (TX); James Young (VA); and David Hippen (WA).

1. Continued Review of the Sample Overview Post Underwriting Comment Chart

Mr. Wicka reminded the Working Group that the issue of timing for the delivery of the policy overview is an issue that the Working Group had not resolved. He said alternate versions of revisions to the Life Insurance Disclosure Model Regulation (#580), as well as sample policy overview documents reflecting the different timing for delivery, had been developed. He said draft samples of the policy overview reflecting delivery at the time of application and delivery post underwriting were developed. Comments were received and put in a chart for discussion by the Working Group. During its Feb. 23 meeting, the Working Group did not finish discussing the comments received on the policy overview delivered post underwriting. He said the Working Group planned to continue going through that comment chart during this meeting and move to comments received on the policy overview delivered at the time of application.

The Working Group continued to review the comment chart for the sample term life overview delivered post underwriting. Comments were received from the American Council of Life Insurers (ACLI), funded consumer representative Birny Birnbaum (Center for Economic Justice—CEJ) and funded consumer representative Brenda J. Cude (University of Georgia).

The Working Group discussed the policy information in the sample overview.

a. What is the name of this product?

Mr. Wicka suggested, and the Working Group agreed to, revising the language in the sample to reflect the more common group level term policy rather than the less common joint policy he had used initially.

b. Does the policy ever expire?

The Working Group discussed the section titled “Does the policy ever expire?” The section currently reads:

Does the policy ever expire?

Yes, you have chosen a 20-year term. Once the term expires, there is an option to renew this policy each year until both insureds reach 95 but the cost of this policy will increase every year after the initial term.

Mr. Wicka summarized comments received from Michael Lovendusky (ACLI), Mr. Birnbaum and Ms. Cude. He suggested, and the Working Group agreed to, the following revised language that combines the suggestions made:

Does the policy ever end? If so, what is the term of the policy?

Yes. The policy ends when the term you choose (20 years) ends, but you can choose to renew this policy each year until you are age 95.

c. What is the death benefit?

The Working Group discussed the section titled “What is the death benefit?” The section currently reads:

The death benefit is $500,000. The death benefit is paid upon the death of the first spouse.
Mr. Wicka suggested, and the Working Group agreed to, the following revisions based on the comments that Mr. Birnbaum and Ms. Cude submitted:

The death benefit is $500,000.

d. Can the death benefit change?

The Working Group discussed the section titled “Can the death benefit change?” The section currently reads:

No, the death benefit will not change unless you request additional coverage.

Mr. Wicka suggested, and the Working Group agreed to, the following revisions based on the suggestions of Mr. Birnbaum and Ms. Cude:

No. The death benefit will stay the same unless you ask, and the company agrees, to increase it.

e. Can I take a loan from my policy?

The Working Group discussed the section titled “Can I take a loan from my policy?” The section currently reads:

This policy does not have any loan options.

Mr. Wicka suggested, and the Working Group agreed to, the following simplified language that Mr. Birnbaum and Ms. Cude suggested:

No. You can’t borrow money from this policy.

f. Does the policy have a waiver of premium option?

The Working Group discussed the section titled “Does the policy have a waiver of premium option?” The section currently reads:

Yes, this policy includes a waiver of premium rider that allows you to not pay premiums if you have been totally disabled for at least 4 months. This rider has an additional cost.

Mr. Wicka suggested, and the Working Group agreed to, the following revised language that Mr. Birnbaum and Ms. Cude suggested:

Yes, you can buy a waiver of premium rider for an extra cost. A waiver of premium rider for this policy means you won’t have to pay premiums after you’ve been totally disabled for at least four months.

g. Can I convert this policy to another type of life insurance?

The Working Group discussed the section titled “Can I convert this policy to another type of life insurance?” The section currently reads:

Yes, this policy may be converted to a permanent life insurance policy prior to the end of the policy term and before you reach age 70.

Mr. Wicka suggested, and the Working Group agreed to, the following revised language that Ms. Cude suggested:

Yes, you can convert this policy to a whole life insurance policy before the policy term ends, as long as you’re younger than age 70.
h. Can I extend the term of coverage?

The Working Group discussed the section titled “Can I extend the term of coverage?” The section currently reads:

Yes, this policy may be renewed annually up to age 95 after the initial term expires. The cost of the policy will increase each year the policy is renewed.

Mr. Wicka suggested, and the Working Group agreed to, the following simplified language that Ms. Cude’s suggestion and relocation of this question to after the following revised questions: “Does the policy ever end? If so, what is the term of the policy?”

Yes. After the initial term ends, you can renew this policy until you are age 95. The premium will increase each year you renew the policy.

i. Are there optional riders available for this policy?

The Working Group discussed the section titled “Can I extend the term of coverage?” The section currently reads:

Are there optional riders available for this policy?

Yes, optional riders are available. To learn what riders are available and their cost, talk to your insurance agent or a company representative.

Mr. Wicka suggested, and the Working Group agreed to, the following revised language that combines language that Mr. Birnbaum and Ms. Cude suggested:

Are there other policy enhancements or optional riders available for this policy?

Yes, there are other policy enhancements – known as riders. Ask the agent, broker, advisor or a company representative offering this product about them.

j. Does this policy have any living benefit options?

The Working Group discussed the section titled “Does this policy have any living benefit options.” The section currently reads:

Does this policy have any living benefit options?

Yes, there is an optional living benefit rider available for an additional cost.

Mr. Wicka suggested, and the Working Group agreed to, the following revised language that combines language that Mr. Birnbaum and Ms. Cude suggested:

Is there a policy option that allows me to access my death benefit while I’m alive?

Yes, for additional premium, you can get part of your death benefit before you die if you are terminally ill.

k. Does this policy accumulate cash value?

The Working Group discussed the section titled “Does this policy accumulate cash value?” The section currently reads:

Does this policy accumulate cash value?

No.
Mr. Wicka suggested, and the Working Group agreed to, the following revised language that combines language that Mr. Birnbaum and Ms. Cude suggested:

No. This policy provides no cash benefits other than the death benefit.

2. Continued Review of the Sample Overview at Time of Application Comment Chart

The Working Group reviewed the comment chart for the sample term life policy overview to be delivered at the time of application. Mr. Wicka explained that the revisions that were agreed-upon for the sample policy overview to be delivered post underwriting would be incorporated into the sample overview to be delivered at the time of application. The summary chart includes comments on those sections where the language will differ based on the timing of the delivery.

a. What are the costs of this Life Insurance Policy?

The Working Group discussed the section titled “What are the costs of this Life Insurance Policy?” The current section reads:

What are the costs of this Life Insurance Policy?

Based on the death benefit selected and the quoted risk class, the premium is estimated to be – per month. The premium may be paid either monthly, quarterly, semi-annually or annually. If you pay premiums monthly, quarterly, or semi-annually, the total premium will be greater than if you pay annually.

Mr. Wicka suggested, and the Working Group agreed to, the following revised language that Ms. Cude suggested:

What does this life insurance policy cost?

Based on the death benefit selected and the quoted risk class, your premium is estimated to be – per year. You may pay the premium monthly, quarterly, semi-annually or annually. If you pay premiums monthly, quarterly or semi-annually, the total premium you pay will be greater than if you pay annually.

b. Does the policy ever expire?

The Working Group discussed the section titled “Does the policy ever expire?” The current section reads:

Does the policy ever expire?

Yes, you have chosen a 20-year term. Once the term expires, there is an option to renew this policy each year until both insureds reach 95, but the cost of this policy will increase every year after the initial term.

Mr. Wicka suggested, and the Working Group agreed to, making changes to this question that parallel the changes made to the sample policy overview delivered post underwriting, with some tweaks that take into account the delivery at the time of application. He explained that the reference to the cost of policy can be removed because that is covered elsewhere in the overview. The revised language reads:

Does the policy ever end? If so, what is the term of the policy?

Yes. The policy ends when the term you chose ends. You may choose a 10-, 20- or 30-year term. You can choose to renew this policy each year until you are age 95.

Mr. Birnbaum said he does not have a problem with the revised language but pointed out that this question seems to provide similar information to the later question: “Can I extend the term of coverage.” Mr. Wicka agreed that the Working Group should revisit this and whether to combine these two questions.

c. What is the death benefit?

The Working Group discussed the section titled “What is the death benefit?” The current section reads:
What is the death benefit?

You have selected a death benefit of $500,000 to generate this quote. You may select a death benefit between $250,000 and $2 million subject to underwriting approval.

Mr. Wicka suggested, and the Working Group agreed to, making changes to this question that parallel the changes made to the sample policy overview delivered post underwriting, with some tweaks that take into account the delivery at the time of application. The revised language reads:

You have chosen a $500,000 death benefit. That amount was used to generate this quote. You may choose a death benefit between $250,000 and $2 million.

d. What do I need to do to obtain this policy?

The Working Group discussed the section titled “What do I need to do to obtain this policy?” The current section reads:

You will need to fill out an application and go through the underwriting process to determine if you are eligible for this product, what the cost of the product will be and the amount of coverage you are eligible to receive.

In the course of considering an insured’s application, an insurer may request or collect health information about the insured in variety of ways. If you qualify, you may be able to obtain this policy without a health questionnaire or physical examination. If you do not qualify, you may still be eligible for this policy, but you will be required to fill out a health questionnaire and undergo a physical examination.

Mr. Wicka suggested, and the Working Group agreed to, the following revised language that included much of the language that Ms. Cude suggested:

You’ll need to fill out an application. You also must go through an underwriting process. Underwriters review your application and decide if you’re eligible to buy this policy, and, if you are, what your premium would be and how much coverage you could buy.

In the course of considering your application, an insurer may request or collect health information about you in a variety of ways.

You might be approved to buy a policy without any information about your health. If you aren’t, you may still be eligible for this policy, but you’ll be required to fill out a health questionnaire and undergo a physical examination.

Mr. Wicka said Mr. Birnbaum had suggested including the additional two questions: “Can I get a discount for a healthy lifestyle? Does the insurer offer products or services to help me stay healthy?” He explained that questions would yield meaningful information for a consumer comparing policies. Mr. Wicka wondered whether this was a benefit added to term life policies. He suggested, and the Working Group agreed, tabling this suggestion for a more fulsome discussion during a future meeting.

Mr. Wicka said he would make the changes to the two alternate versions of the sample overview that the Working Group agreed on during its last two meetings, as well as make corresponding changes to the two versions of Model #580 to post to the Working Group’s web page prior to its next meeting. He said he would like for the Working Group, during its next meeting, to consider a motion to send these preliminary drafts to the Life Insurance and Annuities (A) Committee to aid it in providing guidance to the Working Group on next steps.

Having no further business, the Life Insurance Illustration Issues (A) Working Group adjourned.
Life Insurance Illustration Issues (A) Working Group
Virtual Meeting
February 23, 2021

The Life Insurance Illustration Issues (A) Working Group of the Life Insurance and Annuities (A) Committee met
Feb. 23, 2021. The following Working Group members participated: Richard Wicka, Chair (WI); Jodi Lerner (CA); Chris Struk
(FL); Teresa Winer (GA); Bruce R. Ramge (NE); Jana Jarrett (OH); and John Carter (TX). Also participating were:
Denise Lamy (NH); Sarah Neil (RI); James Young (VA); and David Hippen (WA).

1. Reviewed Next Steps

Mr. Wicka reminded the Working Group of its charge to “explore how the narrative summary required by Section 7B of the
Life Insurance Illustrations Model Regulation (#582) and the policy summary required by Section 5A(2) of the Life Insurance
Disclosure Model Regulation (#580) can be enhanced to promote consumer readability and understandability of these life
insurance policy summaries, including how they are designed, formatted and accessed by consumers.”

Mr. Wicka reminded the Working Group that it had initially decided to add a requirement for a policy overview document in
both Model #580 and Model #582 to fulfill the Working Group’s charge. However, in September 2018, the Working Group
agreed to simplify its approach by revising Model #580 to include the requirement of a policy overview document to accompany
all life insurance policies for delivery with the Life Insurance Buyer’s Guide (Buyer’s Guide). This new approach eliminates
the need for revisions to Model #582.

Mr. Wicka reminded the Working Group that the issue of timing for the delivery of the policy overview was an issue that the
Working Group continues to discuss. He said alternative versions of revisions to Model #580, as well as sample policy overview
documents reflecting the different timing for delivery, had been developed. He said one version maintains the delivery
requirements set out in Model #582 that tie delivery of the policy overview to the delivery of the Buyer’s Guide, which, under
certain circumstances, can be delivered as late as the time of delivery of the policy. The other version requires delivery of the
policy overview at the time of application. He said draft samples for both versions of the policy overview document were
developed for term life insurance policies, noting that comments were requested by Aug. 28, 2020.

Mr. Wicka said comments were received and have been put in a chart for discussion by the Working Group during this meeting.
He said the American Council of Life Insurers (ACLI) wrote a letter to Commissioner Caride and members of the Life Insurance
and Annuities (A) Committee suggesting that the charge of the Working Group to “explore” had been achieved, and the
Working Group should be retired. Mr. Wicka explained that Commissioner Marlene Caride (NJ) would like for the work
product that the Working Group has achieved so far to be brought to the Life Insurance and Annuities (A) Committee so that
the Committee can see a preliminary draft of the work that has been done before it provides guidance.

Mr. Wicka explained that the Working Group will have additional opportunities to make changes to the sample policy overview
documents and Model #580. He reminded the Working Group that this process will need to be undertaken for whole life and
universal life policies. He said he would like to have a preliminary draft to reflect the term life product for the Life Insurance
and Annuities (A) Committee to react to. He reminded the Working Group that the answers in the sample policy overview
documents are based on a particular term life policy that he used in creating the sample. He explained that any necessary
responding changes will be made to Model #580 to reflect changes made to the sample policy overview documents.

2. Discussed Comments Submitted on Sample Policy Overview Documents

Mr. Wicka reviewed the comments that were received on the two versions of the sample policy overview. He said a chart of
the comments had been distributed to the Working Group, interested state insurance regulators and interested parties, and it
was posted on the NAIC website.

The Working Group started with reviewing comments on the sample term life overview delivered post underwriting. Comments
were received from Michael Lovendusky (American Council of Life Insurers—ACLI), funded consumer representative
Birny Birnbaum (Center for Economic Justice—CEJ) and funded consumer representative Brenda Cude (University
of Georgia).
a. Introduction

The Working Group discussed the introductory section. The current introduction states:

This document lists this product’s key features and benefits. You can get a similar summary of key product features from other insurance companies to help you compare similar products. If you have questions about this particular life insurance product, ask the agent, broker, advisor, or a company representative offering this product for clarification. If you have questions about life insurance products generally or about company or agent licensing, contact [insert reference to state department of insurance].

Mr. Birnbaum and Ms. Cude’s comments pointed out that the rest of the document talks about “policies,” not “products.” Mr. Birnbaum also suggested referencing the NAIC website. Ms. Cude suggested removing the reference to contacting a company representative for clarification. Mr. Wicka suggested, and the Working Group agreed, to the following revised introduction:

This document lists this insurance policy’s key features and benefits. You can get a similar summary of key policy features from other insurance companies to help you compare similar policies.

If you have questions about life insurance generally or other types of policies, the National Association of Insurance Commissioners has useful information at https://content.naic.org/consumer/life-insurance.htm/

If you have questions about this particular life insurance policy, ask the agent, broker, advisor, or a company representative.

If you have questions about company or agent licensing, contact [insert reference to state department of insurance].

b. Information About the Insured

The Working Group discussed comments received on the section titled “Information about the Insured.”

The ACLI pointed out that the sample says the overview is prepared for Mr. and Mrs. Smith, when most policies are owned by an individual, noting that the applicant should be named, along with the risk class.

Mr. Birnbaum suggested titling the section “Information We Use to Determine Your Annual Premium” and included a list of information beyond the age and sex provided for in the sample overview that is collected from the policy owner, including family history, tobacco usage, occupation and hobbies, as well as information obtained from third parties, such as motor vehicle registration, auto, home and other insurance claims, driving records, prescription history and criminal history. Mr. Birnbaum also suggested including the possible range of risk classes before naming the risk class to which the policy owner belongs.

Mr. Wicka said he would revise this portion of the overview for review by the Working Group. The Working Group agreed with this plan.

c. What Are the Costs of This Life Insurance Policy?

The Working Group discussed the comments received on the section titled “Cost Information.” The current section reads:

The premium is X per month.

The premium must be paid either monthly, quarterly, semi-annually or annually. If you pay premiums monthly, quarterly, or semi-annually the total premium will be greater than if you pay annually.

Mr. Wicka suggested, and the Working Group agreed, to make the following revision, which is a combination of suggested revisions from Mr. Birnbaum and Ms. Cude:

The premium is $AAA annually or $BBB quarterly or $CCC monthly.
You may pay the premium monthly, quarterly, semi-annually or annually. If you pay premiums monthly, quarterly or semi-annually, the total premium you pay will be more than if you pay annually.

d. Will My Premium Ever Change?

The Working Group discussed comments received on the section titled “Will my premium ever change?” The current section reads:

No, the premium is guaranteed to remain level for the term of the policy. After that term expires, the premium will increase annually if you chose to renew the policy.

The Working Group discussed language suggestions from Mr. Birnbaum and Ms. Cude.

Mr. Wicka pointed out that the answer “no” is followed by a description of the circumstances when the premium may increase, which is confusing. Mr. Wicka suggested, and the Working Group agreed, to the following language that eliminates the “no” and incorporates the simplified language suggested by Mr. Birnbaum and Ms. Cude:

The premium will stay the same for the initial term of the policy. After that term ends, the premium will increase each year if you choose to renew the policy.

e. Are There Any Costs if I Decide to Cancel the Policy?

The Working Group discussed the section titled “Are there any costs if I decide to cancel the policy?” The current section reads:

No, there are no costs to cancel this policy. However, this policy does not accumulate cash value and you will not receive any return of the amount of premiums paid.

Mr. Birnbaum and Ms. Cude submitted language suggestions to clarify the section.

Mr. Wicka suggested, and the Working Group agreed, to the following language that is a combination of Mr. Birnbaum’s and Ms. Cude’s suggestions:

Are there any costs if I decide to cancel the policy? Do I get any money back if I cancel the policy?

No, there are no costs to cancel this policy. However, if you do cancel this policy, you won’t get any money back.

f. Can I Lower the Death Benefit Amount to Reduce Premium?

The Working Group discussed the section titled “Can I lower the death benefit amount to reduce premium?” The section reads:

Can I lower the death benefit amount to reduce premium?

No.

Mr. Wicka said the ACLI comment letter pointed out that reducing benefits to reduce premium is not a practice for this type of policy and would likely not be permitted under state laws, because it alters the terms of the contract and would be tantamount to a new policy. Mr. Wicka and the Working Group agreed to eliminate this question.

The Working Group agreed to reconvene to finish going through the comments submitted.

Having no further business, the Life Insurance Illustration Issues (A) Working Group adjourned.
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The Life Actuarial (A) Task Force met April 8, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Judith L. French, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Perry Kupferman, Thomas Reedy and Ted Chang (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).


The Task Force met March 18, 2021; March 11, 2021; March 4, 2021; Feb. 25, 2021; Feb. 11, 2021; Feb. 4, 2021; Jan. 28, 2021; Jan. 21, 2021; and Dec. 17, 2020. During these meetings, the Task Force took the following action: 1) adopted its 2020 Fall National Meeting minutes; 2) adopted amendment proposal 2020-11, which allows exemption of policies from prior issue years when there is a change in the life principle-based reserving (PBR) exemption requirements; 3) exposed amendment proposal 2020-12, which creates consistency between clearly defined hedging strategy (CDHS) requirements in VM-20, Requirements for Principle-Based Reserves for Life Products, and VM-21, Requirements for Principle-Based Reserves for Variable Annuities, and revises hedge modeling to only require CDHS if modeling future hedging reduces the reserves under VM-20 or total asset requirement (TAR) under VM-21; and 4) exposed amendment proposal 2020-13, which revises the asset collar language for negative modeled reserves.

Mr. Weber made a motion, seconded by Ms. Ahrens, to adopt the Task Force’s March 18, 2021(Attachment One), March 11 and March 4, 2021 (Attachment Two), Feb. 25, 2021 (Attachment Three), Feb. 11, 2021 (Attachment Four), Feb. 4, 2021 (Attachment Five), Jan. 28, 2021 (Attachment Six); Jan. 21, 2021 (Attachment Seven); and Dec. 17, 2020 (Attachment Eight) minutes. The motion passed unanimously.

2. **Adopted the Report of the Longevity Risk (E/A) Subgroup**

Mr. Weber made a motion, seconded by Ms. Ahrens, to adopt the report of the Longevity Risk (E/A) Subgroup (Attachment Nine). The motion passed unanimously.

3. **Adopted the Report of the Guaranteed Issue (GI) Life Valuation (A) Subgroup**

Mr. Weber made a motion, seconded by Ms. Ahrens, to adopt the report of the Guaranteed Issue (GI) Life Valuation (A) Subgroup (Attachment Ten). The motion passed unanimously.

4. **Adopted the Report of the Experience Reporting (A) Subgroup**

Mr. Weber made a motion, seconded by Ms. Ahrens, to adopt the report of the Experience Reporting (A) Subgroup (Attachment Eleven), including its March 2 minutes (Attachment Twelve). The motion passed unanimously.

5. **Adopted the Report of the Indexed Universal Life (IUL) Illustration (A) Subgroup**

Mr. Weber made a motion, seconded by Ms. Ahrens, to adopt the report of the Indexed Universal Life (IUL) Illustration (A) Subgroup (Attachment Thirteen). The motion passed unanimously.
6. **Adopted the Report of the Variable Annuities Capital and Reserve (E/A) Subgroup**

Mr. Weber made a motion, seconded by Ms. Ahrens, to adopt the report of the Variable Annuities Capital and Reserve (E/A) Subgroup (Attachment Fourteen). The motion passed unanimously.

7. **Adopted the Report of the Valuation Manual (VM)-22 (A) Subgroup**

Mr. Sartain said that Subgroup meetings were focused on addressing comments on the American Academy of Actuaries’ (Academy) Annuity Reserves and Capital Work Group (ARCWG) preliminary framework. He said the Subgroup’s goal is to provide recommendations to the Task Force on the most important items proposed by the ARCWG. The ARCWG is expected to present a draft of requirements for non-variable annuities, which the Subgroup anticipates exposing for comment by mid-summer. He said the field test, initially planned for fall 2021, has been pushed to February 2022 through June 2022, which necessitates pushing the target effective date for the VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, revisions from January 2023 to January 2024.

Mr. Sartain made a motion, seconded by Mr. Chou, to adopt the report of the VM-22 (A) Subgroup, including its March 17 (Attachment Fifteen), March 3 (Attachment Sixteen), Feb. 24 (Attachment Seventeen), Feb. 10 (Attachment Eighteen), Feb. 3 (Attachment Nineteen), Jan. 27 (Attachment Twenty) and Jan. 20 (Attachment Twenty-One) minutes. The motion passed unanimously.

8. **Exposed Amendment Proposal 2020-10**

Marianne Purushotham (Academy Mortality Improvement Life Working Group [MILWG] and Society of Actuaries [SOA] Preferred Mortality Project Oversight Group [Joint Committee]) presented a recommendation (Attachment Twenty-Two) for applying a prudent level of future mortality improvement to the VM-20 reserve methodology for inclusion in the 2022 Valuation Manual. She said the first phase of the recommendation is the development of mortality improvement factors that will be reviewed annually in a process similar to what is used for the valuation basic table (VBT) scales. She noted that the scale will be initially based on the best estimate of recent historical mortality improvement. The rates will linearly grade to the long-term mortality improvement rates (LTMIR) over the first 10 years, remain level for five years and linearly grade to no improvement at year 20. The LTMIR is defined as the average of projection years 10–15 from the Social Security Administration (SSA) intermediate projection known as “Alt 2.”

Ms. Purushotham said the scale will be initially based on the best estimate of recent historical mortality improvement. The rates will linearly grade to the long-term mortality improvement rates (LTMIR) over the first 10 years, remain level for five years and linearly grade to no improvement at year 20. The LTMIR is defined as the average of projection years 10–15 from the Social Security Administration (SSA) intermediate projection known as “Alt 2.”

Ms. Purushotham said the recommendation proposes applying a flat margin to reduce the basic scale. The size of the margin will be determined through reserve model testing. She said other issues for immediate consideration are the short-term and long-term impacts of COVID-19, the impact of opioid addiction, the threshold for materiality and the socioeconomic-based mortality differences between the general and insured populations. She said consideration will also be given later to cohort effects on mortality improvement.

Ms. Hemphill said amendment proposal 2020-10 provides language for inclusion of the future mortality improvement proposal into the Valuation Manual that will reduce reserve redundancy. She said reflecting future mortality improvement will be beneficial to the yearly renewable term (YRT) field test discussions. Mr. Carmello asked if the application of the factors resulting in mortality deterioration should be mandatory. Ms. Hemphill said the proposal is intended to cover that issue. She agreed to amend the exposure to ask for comments on whether the changing language in VM-20 Section 9.C.7. from “may” to “shall” will clarify that intent. Mr. Robinson suggested that the term “prudent estimate mortality” be changed to “prudent estimate for mortality” to match the terms defined in the Valuation Manual. Mr. Chupp asked how the margin will be applied when there is mortality deterioration. Ms. Purushotham said the issue has not yet been decided. Mr. Chupp suggested that mortality improvement should be applied to anticipated experience assumption instead of the prudent estimate assumption.
Ms. Ahrens made a motion, seconded by Mr. Schallhorn, to expose amendment proposal 2020-10 (Attachment Twenty-Three), including the requests to change “may” to “shall” and “prudent estimate mortality” to “prudent estimate for mortality,” for a 45-day public comment period ending May 25. The motion passed, with Mr. Chupp dissenting.

9. Discussed the ESG Implementation Timeline and Overview of the Treasury Model

Mr. Boerner shared the Statement on Level of Documentation, Conning Intellectual Property (Attachment Twenty-Four) to help frame the discussion on economic scenario generator (ESG) documentation. Pat Allison (NAIC) and Scott O’Neal (NAIC) presented a slide deck (Attachment Twenty-Five) displaying the common themes in the ESG comment letters submitted by the Academy (Attachment Twenty-Six), the American Council of Life Insurers (ACLI) (Attachment Twenty-Seven), Equitable (Attachment Twenty-Eight), Mark Tenney (unaffiliated) and Ted Pedersen (unaffiliated) (Attachment Twenty-Nine), Steve Craighead (unaffiliated) and Mark Tenney (Attachment Thirty), Link Richardson (American General) (Attachment Thirty-One), and Matt Kaufmann (Moody’s Analytics) (Attachment Thirty-Two). The slide deck also displayed the responses provided by NAIC staff and Daniel Finn (Conning Inc.), and where applicable listed the decisions to be considered by the Task Force.

Connie Tang (Prudential) said that while it is a good idea to think about the targets to control the level of negative rates, it would be helpful to think about what the right scenario properties and behaviors are. She also raised concerns about targeting a steady state distribution. Jason Kehrberg (Academy) expressed an interest in seeing how adjusting one parameter may affect other parameters.

Mr. O’Neal said several comments on the complexity of the corporate model were received. He said the decision on the level of complexity desired for the corporate model is the purview of the Task Force. Mr. Finn said the key components are captured in the current version of the Conning ESG to reduce complexity. He noted the need for additional documentation. Mr. Robinson asked if a simpler model is possible. Mr. Finn responded affirmatively, noting that issues such as calibration and coverage would have to be considered.

Mr. O’Neal said commenters asked about the extreme equity returns provided in the ESG exposures. Mr. Finn said over long periods, cumulative returns will converge toward a distribution that is roughly lognormal. He said expected means and standard deviations of the annual returns must be adjusted to moderate the returns. He said the Task Force should decide whether to alter the targets for the mean and standard deviation of the equity model to limit the extremities of the tail scenarios.

Mr. Finn said the current calibration process considers that the equity model has a direct link to U.S. Treasury rates to attempt to recognize that the model should be arbitrage-free and work in different environments. He said the link also recognizes that investor decisions are based on the returns of all available investments. He said the Task Force should decide whether to continue using the link to Treasury rates. Randall McCumber (Lincoln Financial Group) said the equity model should consider that both the rate component and risk premium can vary. Ms. Tang said linking equity returns to changes in interest rates is preferable to a formulaic linkage of equities to interest rates in every period. Steve Tizzoni (Equitable) said the Equitable comment is supportive of the structural linkage between interest rates and equity returns. Mr. Tenney said the Cox-Ingersoll-Ross equilibrium paper shows that there is no formulaic relationship that provides a number that can be added to a short-term rate to estimate equity returns. Mr. Chang said the equity model is designed so that the level of the risk premium is more important than the interest rate.

Mr. Finn said a proposed model for international equities was recently released. The model uses regression equations for the pricing and income of international diversified equities and a separate regression, based on the emerging markets, for the aggressive equities. He said returns for the index for Europe, Australasia and Far East (EAFE) has historically tracked lower that the Standard & Poor’s (S&P) 500 and the Russell 2000 indices, despite being riskier. He said the Task Force will have to determine whether to maintain that relationship or to use a risk framework more like the S&P 500 or the Russell 2000.

Mr. O’Neal said the ACLI and the Academy expressed concern that the current timeline is insufficient to allow effective review of the ESG. He said the NAIC plans to continue with the current timeline but will adjust dates as needed to appropriately address industry concerns.

In response to comments on the data format, Mr. Finn said that Conning is amenable to providing data in whatever format the industry may require. Mr. Kehrberg said it would be preferable to have additional data related to evaluating scenarios. Mr. Finn said that he is happy to have discussions on the data companies feel are necessary. On the issue of documentation, Mr. O’Neal noted that an appropriate amount of additional documentation is being prepared for release. He said the recently updated ESG
question-and-answer (Q&A) document (Attachment Thirty-Three) is available on the related documents tab of the Task Force web page.

10. **Heard an Update on SOA Research and Education**

Dale Hall (SOA) gave a presentation (Attachment Thirty-Four) on 2020 group and individual life COVID-19 mortality experience by quarter for various demographic categories and geographic regions. He noted that in the general population, the highest actual to expected ratios occurred in the age range from 35 to 54. He noted that after seeing mortality continue to improve in 2019, the 2020 results showed a 16% negative improvement. Mr. Hall noted that the presentation included a listing of other studies completed by the SOA.

11. **Heard an Update from the Academy LPC on its Recent Activities and 2021 Priorities**

Laura Hanson (Academy Life Practice Council—LPC) gave a presentation (Attachment Thirty-Five) on the LPC’s recent activities and its 2021 priorities. She also noted that the C-1 Work Group has provided the Life Risk-Based Capital (E) Working Group updated C-1 bond factors that reflect the new corporate tax rates. She highlighted the ARCWG work on VM-22 and discussed the Academy webinars and boot camps planned for 2021. She listed a few of the Academy efforts supporting its promotion of diversity and inclusion within the actuarial profession and in the broader insurance industry.

12. **Adopted Amendment Proposal 2020-13**

Mr. Weber made a motion, seconded by Mr. Leung, to adopt amendment proposal 2020-13 (Attachment Thirty-Six). The motion passed unanimously.

13. **Exposed Amendment Proposal 2021-04**

Mr. Bayerle said amendment proposal 2021-04 clarifies the references to Internal Revenue Code Section 7702 in VM-02, Minimum Nonforfeiture Mortality and Interest.

Mr. Leung made a motion, seconded by Mr. Schallhorn, to expose amendment proposal 2021-04 (Attachment Thirty-Seven) for a 21-day public comment period ending April 28. The motion passed unanimously.

14. **Exposed Amendment Proposal 2021-03**

Ms. Tang said amendment proposal 2021-03 updates VM-21 Section 6 to reflect the increase of the required minimum distribution (RMD) age from 70½ to 72. She said the Task Force should consider revising the wording in VM-21 Section 6.C.5.n to clarify that changes in the RMD age may require recalculation of the cohort weighting. She agreed to add a sentence to the exposure cover page to call attention to the potential need for additional clarification.

Mr. Leung made a motion, seconded by Mr. Weber, to expose amendment proposal 2021-03 (Attachment Thirty-Eight) for a 21-day public comment period ending May 3. The motion passed unanimously.

15. **Re-Exposed Amendment Proposal 2020-12**

Ms. Hemphill said amendment proposal 2020-12, previously exposed for public comment through March 26, has been revised to reflect the comments received from Nationwide Financial (Attachment Thirty-Nine), the ACLI (Attachment Forty) and William Wilton (Attachment Forty-One).

Mr. Robinson made a motion, seconded by Mr. Schallhorn, to expose revised amendment proposal 2020-12 (Attachment Forty-Two) for a 21-day public comment period ending April 28. The motion passed unanimously.

16. **Discussed the Mortality Data Collection Project**

Ms. Allison said the VM-51, Experience Reporting Formats, mortality data collection will begin soon. She presented an update (Attachment Forty-Three) on the mortality data collection project.

Having no further business, the Life Actuarial (A) Task Force adjourned.
The Life Actuarial (A) Task Force met March 18, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Judith L. French, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li and Steve Ostlund (AL); Ricardo Lara represented by Ben Bock and Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Dana Popish Severinghaus represented by Vincent Tsang (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. Discussed the ACLI Proposal to Extend the Nonforfeiture Timing

Mr. Boerner said the passage of the federal Consolidated Appropriations Act, 2021 in December 2020 changed the calculated nonforfeiture interest rate for policies with guarantees of greater than 20 years to 3.75%. The American Council of Life Insurers’ (ACLI’s) amendment proposal 2021-02 (Attachment One-A) recommends allowing the use of the 2020 nonforfeiture rates through June 2022, instead of through December 2021 as allowed by the Standard Nonforfeiture Law for Life Insurance (#808). Mr. Boerner said that authority that Model #808 gives the Valuation Manual is limited to setting the nonforfeiture rate for the calendar year. He said that Model #808 allows companies the option of using the nonforfeiture rate in effect at the end of the previous calendar year. He noted that the option cannot be extended by the Valuation Manual, as the ACLI proposes. Several state insurance regulators concurred with Mr. Boerner’s interpretation of Model #808. Dan Schelp (NAIC) said while he understands the ACLI’s concerns, his reading of Model #808 and the Valuation Manual does not support the Valuation Manual changes proposed by the ACLI.

Mr. Carmello suggested that the Valuation Manual could be revised to set a fixed rate to be used for the 2022 calendar year instead of using the methodology currently in place. Mr. Serbinowski noted that Mr. Carmello’s suggestion will also allow for use of that fixed rate for 2023. Brian Bayerle (ACLI) said the ACLI understands the issues outlined by the state insurance regulators and will consider revising the amendment proposal to conform to the existing requirements. He said market issues will arise if companies are unable to get policy filings approved before the end of 2021. Paul Graham (ACLI) asked the state insurance regulators to consider the impact on small companies that had the nonforfeiture rate set at 4% for 2021 and anticipated using that rate for 2022. He said the small companies will experience resource constraints if required to change the rate to 3.75% for 2022.

Mr. Weber said the potential market disruptions is a policy issue and should not be addressed with technical solutions. He asked if the ACLI had raised the issue with the Life Insurance and Annuities (A) Committee. Mr. Graham said he had not discussed the matter with the Committee. Mr. Boerner said he would update the Committee chair on the issue. Mr. Graham agreed to withdraw the amendment proposal but said he believes a path to a solution may still be available through the Valuation Manual. He said the ACLI will consider potential next steps, including going to the Committee.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Life Actuarial (A) Task Force / Health Actuarial (B) Task Force
Amendment Proposal Form

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

Brian Bayerle, ACLI – Provides a six month deferral of 2021 nonforfeiture requirements and edits previously adopted changes to VM-02 for improved clarity and to remove potential circularity.

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

Valuation Manual (January 1, 2021 edition), VM-02 Section 3.A

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

See attached.

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

For 2021, the calculated 20+ duration life nonforfeiture rate is 3.75%. The 2021 Valuation Manual sets a floor at the level of the Cash Value Accumulation Test rate within Section 7702 of the U.S. Internal Revenue Code. Given that the Internal Revenue Code, Section 7702 interest rate, and therefore the statutory nonforfeiture rate, was not known until the very end of December 2020, there is a 6-month reduction in the normal 18-month timeframe available to re-price and obtain state insurance department approval of policy forms. In light of the highly critical need for companies to redesign products, as well as state insurance departments to complete their review prior to 1/1/2022 (otherwise certain products would not be available in the marketplace), we suggest delaying the 1/1/2022 effective date for the standard nonforfeiture rate to 7/1/2022 through an amendment to VM-02 in the NAIC Valuation Manual. We have a concern that the large volume of new policy forms expected to be filed, coupled with the compressed timeframe resulting from the date of passage of Section 7702 reform, could lead to an especially challenging burden for state departments of insurance to complete review within this period of time. The proposal leaves open the possibility that, if delays do occur, certain products can remain available in the first six months of 2022. Further, the amendment would clarify the language in the previously adopted edits to VM-02 to avoid any potential circularity.
Section 3: Interest

A. The nonforfeiture interest rate for any life insurance policy issued in a particular calendar year beginning on and after the operative date of the Valuation Manual shall be equal to 125% of the calendar year statutory valuation interest rate defined for the NPR in the Valuation Manual for a life insurance policy with nonforfeiture values, whether or not such sections apply to such policy for valuation purposes, rounded to the nearer one-quarter of 1%, provided, however, that the nonforfeiture interest rate shall not be less than the Applicable Accumulation Test Minimum Rate in the Cash Value Accumulation Test under Section 7702 (Life Insurance Contract Defined) of the U.S. Internal Revenue Code.

1. Through June 30, 2022, companies may use the nonforfeiture life insurance interest rate in place during 2020 to determine the nonforfeiture interest rate for life insurance in this section.

   **Guidance Note:** This edit is to link with the change in the requirements in Section 7702 of the U.S. Internal Revenue Code. Companies may use the 2020 nonforfeiture life insurance interest rates in calendar year 2021 and the first six months of calendar year 2022.

2. Any option provided that allows companies to calculate minimum nonforfeiture values using a nonforfeiture interest rate not exceeding the nonforfeiture rate in the preceding calendar year shall refer to the nonforfeiture interest rate in effect on the last day of the preceding calendar year.

   **Guidance Note:** The intention of the above paragraph is to address language in Section (5c)(H)(1) of the NAIC Standard Nonforfeiture Law for Life Insurance (Model #808), such that the nonforfeiture interest rate in calendar year 2023 would only be permitted to refer to the nonforfeiture interest rate in effect at 12/31/2022.

   **Guidance Note:** For flexible premium universal life insurance policies as defined in Section 3.D of the Universal Life Insurance Model Regulation (#585), this is not intended to prevent an interest rate guarantee less than the nonforfeiture interest rate.
The Life Actuarial (A) Task Force met March 4 and March 11, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Judith L. French, Vice Chair, represented by Jason Wade (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li and Steve Oslund (AL); Ricardo Lara represented by Ben Bock and Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severingham represented by Vincent Tsang (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); Scott A. White represented by Craig Chupp (VA); and James A. Dodrill represented by Tim Sigman (WV).

1. **Discussed the ESG Questions Received through March 4**

Dan Finn (Conning) discussed the economic scenario generator (ESG) questions (Attachment Two-A) received from interested parties and interested state insurance regulators through March 4. Responses were focused on treasury and equity model questions; corporate model and governance questions will be addressed later. The questions and responses will be added to the Question and Answer (Q&A) document (Attachment Two-B) on the Conning website. Mr. Finn said a free trial of the GEMS application programming interface (API) is available to companies interested in testing its functionality.

Connie Tang (Prudential) asked if documentation of the interrelationships of the treasury, equity and corporate models can be made available. Mr. Finn said Conning is currently working on that documentation.

2. **Discussed the ESG Questions Received through March 11**

On March 11, Scott O’Neal (NAIC) described the format of the Question Log (Attachment Two-C). Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI has identified a few challenges, including the availability of documentation. He discussed the ACLI questions included in the Q&A document. Mr. Finn said Conning has focused solely on the characteristics of the model and the calibration. He said Conning has made no effort to determine the model’s impact on reserves and capital. He said the current calibration is intended to provide a starting point that will be modified based on the feedback from state insurance regulators and companies. He said the information informing the calibration will not be limited to historical data. He said decisions about issues, such as volatility, will be made later. Mr. Bayerle said more documentation is needed before the ACLI is able to provide substantive comments. He said the totality of the model, including the interaction between its components, must be understood before making decisions on parameters. Mr. Finn said without calculating the reserve components, the types of information the ACLI is asking about is difficult to provide. Ms. Tang said there needs to be an understanding of the origination of the ESG components and their underlying dynamics. Mr. Finn said Conning is willing to provide more data, test more parameters and conduct more sensitivity tests if companies feel it will be helpful. He said Conning is also willing to test parameters over different time horizons.

Mr. Finn continued answering questions submitted by Chris Conrad (American Academy of Actuaries—Academy), Mr. Chupp, Link Richardson (American International Group—AIG), and Mark Tenney (Mathematical Finance Company).

The recordings of the virtual meeting are available on the Related Documents tab of the Task Force website.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Questions Received for Discussion on the March 4 LATF Call

Craig Chupp

1. How are the jump parameters determined and/or set? Does the model reflect recent jump data or long-term averages or a combination of both? Looking at historical data, how does the model determine when a jump has occurred and the magnitude of the jump? For example, considering the movement in the S&P 500 during the first couple of quarters of 2020, was this considered a jump or multiple jumps? If so, what was the criteria used to determine if a jump occurred? Over how many days was the jump considered to occur and what was the magnitude of the jump?

2. How is the value of the mean reversion speed parameter in the Variance Equation determined?

Vincent Tsang

1. In the graph “Equity Equation – Impact of Jumps” on page 10 of the ppt slides, the projected cumulative wealth factors from AIGR and GEMS at the end of the 30th year can be approximated by the line

\[ \text{AIGR cumulative wealth factor} = 1.3082 \times (\text{GEMS cumulative wealth factor}) + 1.4558 \]

For example, if GEMS cumulative factor is 4500%, the AIRG cumulative factor is approximately 6000%. Please explain the driver(s) which cause AIRG’s cumulative wealth factor being significantly higher than GEMS’s cumulative factor. Given that the title of the slide is “Equity Equation – Impact of Jumps,” is the difference in wealth factors attributable to the assumed jumps? If not, why?

2. In the first page of the ppt slides “Equity Equation,” the differential equation is listed as follow:

\[ \frac{dS(t)}{S(t)} = \left[ (r(t) - D(t)) + \mu_0 + \mu_1 V(t) - \lambda m V(t) \right] dt + \sqrt{V(t)} dW_1(t) + \gamma dN(t) \]

As the jump parameters \( \lambda \) and \( V(t) \) are positive and \( m \) is negative in page 8, the drifting factor due to the jump parameters is negative. Does it mean that the jump parameters would reduce the drifting factor for the equity return?

Connie Tang

1. [Describe] the mechanics of Conning’s calibration.

2. [Discuss] Conning’s model selection decision and recommended calibration, e.g.,
   a. How did they pick this type of equity / rate linkage over other approaches, especially given that the different types can produce very different reserve/capital sensitivities?
**Questions Received for Discussion on the March 4 LATF Call**

b. How did they get comfortable with the appropriateness of the changes in these sensitivities when certain LATF parameters were incorporated vs. their Standard Calibration?

3. [Describe the] out of the box capabilities in GEMS to allow different relationships (vs. just substituting different parameter values)?

4. [Are there] not out-of-the-box changes that Conning would be willing to consider / implement?

**Connie Tang Section G Questions**

1. What would actually change on a monthly basis?
   a. Is Conning only updating initial conditions (and any LATF-specified formulaic updates – e.g., MRP)?
   b. Are the updates purely mechanical, or are there any subjective tweaks or judgment calls?

2. What is the LATF exposure / testing / approval process for:
   a. Other regularly scheduled / routine updates beyond initial condition or formulaic updates (E.g., bringing an additional year of historical data into the calibration?)
   b. More fundamental model changes (e.g., structural changes, changes in calibration methodology / philosophy)

3. What is the process if something unexpected / unanticipated happens in the monthly updates – e.g., routine (business as usual) updates create scenarios that suddenly don’t make sense, or the calibration produces invalid parameters?
   a. What is the process for reviewing and detecting questionable or inappropriate scenario distribution properties before scenarios are posted? (There should be checks for reasonability of distribution properties and not just validation that specific targets were reproduced. The scenarios exposed in Dec. reproduced LATF’s / Conning’s intended targets, but the process should have identified the inappropriate distribution of yield curve shapes.)
   b. What is the escalation process if issues are detected? (Does Conning make judgments on their own? Are regulators and industry at risk of being surprised when unusual scenarios produce unusual reported results or changes in reported results that don’t align with prior sensitivities/dynamics?)

**Scott Schneider**

1. Will scenarios be consistent from month to month? In other words, will new scenario number 1 be comparable to old scenario number 1 or will the scenarios be an entirely new random set? We would like to see consistency from period to period.

2. When parameters are updated, will Conning provide scenarios as of the valuation date before and after changing each parameter? Before and after changing all parameters in aggregate? We would like to be able to assess the impact of the change of each parameter.
Questions Received for Discussion on the March 4 LATF Call

3. If 10,000 scenarios are not enough for convergence (particularly for CTE98), what do we do?

4. What time steps will be available (daily, weekly, monthly, quarterly, annual) within the scenarios? How many years of projection will be provided in each scenario? We would like the ability to get time steps of any frequency from daily to annual. We would also like 90 years’ worth of time steps.

5. Will individual states (e.g. New York) have different requirements? We would like the scenarios to be provided with and without individual state requirements.

6. We believe that Conning has stated that the interest rate generator (GEMS) is arbitrage-free, but the equity return generator appears to add a positive risk premium resulting in scenarios which are not arbitrage-free. Is our understanding correct? If so, will there also be an arbitrage-free version of the equity scenarios?

ACLI

1. Criteria / stylized facts / distribution properties
   a. What criteria or stylized facts did Conning apply and how did they assess the pros/cons when selecting / developing their ESG model?
   b. How does Conning assess the reasonability of scenario outputs (i.e., in the exposed scenarios and on an ongoing basis)?
   c. What adjustments have been made either in model development or during the generation of scenarios as a result of these considerations?
      (Comprehensive information on these items should also be included in Conning’s documentation.)

2. It seems like the selected model and proposed calibration approach may increase procyclicality (and/or create unintuitive relationships). How did that factor into the model decisions and recommendation?
Questions Received for Discussion on the March 4 LATF Call

Moody's Analytics

1. The model seems to support the fitting of the initial yield curve using a shift function. The limitation to 3 points seems to be a particular calibration choice. We are aware that this choice may benefit the stability of the long-term rate distribution, but it would be useful to be clear on the limitation of the model implementation and where calibration choices are chosen to mitigate these constraints in the model.

2. The mechanism to remove the discrepancies [between the actual and modeled starting yield curve] is not clear. Does this mechanism still preserve the arbitrage free properties of the model?

3. The choice of this value 3 [used in the process to fit the initial yield curve] seems to be without any motivation. What impact do these choices have on the scenario produced by the model and their robustness over short term or long-term projection horizons. The NAIC could consider not using this feature at all, i.e. accept the limitation in the model that it will not fit accurately curve or could look to motivate the choice of decay factor based on historical rate behavior/mean reversion speed etc....

4. The parametric fit of the yield curve could lead to very different long-term forward rates driving projected yields on different valuation dates i.e. from month to month. This could mean that analysis sensitive to long term projected rates could be unstable. It could be useful for the NAIC to consider the testing of the model on different valuation dates to understand the stability of the long-term scenarios and related distributions. In particular, looking at historical dates with very different starting curves and long-term forward rates (considering levels and perhaps also different gradients)

5. The model should produce a variety of yield curve shapes, and they should change over time. Is the NAIC setting targets for the correlation between different points on the yield curve or will there be alternative criteria to constrain the behavior of rates across the term-structure? A set of clear quantitative targets for correlation between different points on the yield curve can help validate the model performance objectively in this area.

6. Interest rates can be negative. Will the NAIC consider a test of the scenarios where the curve is initialized using the German or Swiss yield curve to get and understanding of how well the model will handle negative initial starting curves?

7. Is the NAIC constraining the forward expected level of the rates as part of the calibration? If so, it would be useful to understand how the model's distributions are impacted by rate levels that could be lower than current levels. Information from European, Swiss and Japanese yield curves and implied expectations can be a useful stress test to understand how the model might behave in the event the US yields move negative.

8. There are examples of negative rates and dynamics across several developed market. Have the NAIC consider extending the calibration data set beyond just US data to improve and broaden the historical information embedded in the calibrations?
Questions Received for Discussion on the March 4 LATF Call

9. Has the NAIC considered how to assess the impact of the frequency and magnitude of negative rates produced by the model?

10. The interest rate generator should be arbitrage free. There are a few variations of the classical CIR type model mentioned in the supplied documentation. It would be good to understand if these model adjustments (floor, decay scaling, term premium assumptions) can break or disrupt the arbitrage free properties of the model. Are the NAIC producing any test of validations to assess these properties in the model?

11. Returns should be provided for funds representative of those offered in U.S. insurance products. How should insurers approach the generation of additional fund returns if the provided return series are not representative of those offered in their particular insurance products?

12. Are the credit spread model and related bond fund returns arbitrage free?

13. The NAIC have not specified any modelling constraints on the credit spread or corporate bond return modelling. Are there any features that are needed from this model? e.g. ability to capture negative spreads, stability of return distributions over long time horizons, relationship between expected defaults and spread levels, nature of the volatility of spread and defaults, volatility of returns etc.

14. If a stochastic spread and ratings-based model is chosen, how should insurers running sensitivities or projections of reserves consider updating the initialization/features of this model?

15. How has the NAIC decided on the relevant number of [corporate bond] rating classes to be modelled?

16. The modelling mentions BB rated bonds, but the model specification only has a generic high yield asset. How will the NAIC ensure this calibration is appropriate and does not understate or overstate risk due to fact the model does not capture B or CCC rated spread/bonds?

17. Is the NAIC specifying any additional criteria on the correlation of transitions/defaults across issuers and how this impact the bonds in the portfolios that are being modelling as part of the bond fund universe?

Additional Moody’s Analytics Questions

Arbitrage Free Nature of the Models

1. The models discussed are generally considered arbitrage-free pricing models. Is this requirement something that the NAIC wants to be addressed by all risk factors: interest rate, equity returns and credit spread/returns?

2. Is this criterion met for the chosen models? If it is not met, what specific implementation/calibration/configuration decisions have been made to prevent the model from being arbitrage free?

3. If the models are not arbitrage free, what additional validations and testing is being considered to ensure the model produces appropriate behaviour, stable risk premium and reasonable outcomes within each stochastic trial?
Questions Received for Discussion on the March 4 LATF Call

Interest Rate Model
1. Is the NAIC expecting to produce alternative calibrations with changes to the starting rate levels to help insurers understand the impact of the initial curve on the projected distribution? It would be good to understand the stability of the model/distributions/risk-premia if the model was initialized at a lower (or significantly higher) level than today (e.g. for a realistic example you may consider the current level of German interest rates).

Corporate Bond and Spread Model
1. Will further technical documentation on the corporate bond model (including detailed formulas, parameters, and calibration methods) be provided?
2. Can you provide details on the “stochastic modulator µ(t)” process, its parameters and its calibration?
3. The use of the jump in the Equity model is interesting. It can be challenging to calibrate and constrain these types of jump models with historical data. How is this achieved?
This document provides a summary of questions and answers relating to the development of the new ESG to be used for statutory reporting purposes. This ESG will produce real-world interest and equity scenarios to be prescribed for use in calculations of life and annuity Statutory reserves according to the Valuation Manual (e.g. VM-20, VM-21) and capital under the NAIC RBC requirements (e.g. C3 Phase 1, C3 Phase 2). This is a living document. As additional questions are received, this document will be expanded. Please email Reggie Mazyck, rmazyck@naic.org, with additional questions or any requests for clarification relating to this document.

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Section A: Treasury Model

Q1. Does the GEMS Treasury model require the initial state variables to be non-negative? If so, what happens if the initial Yields produce a negative state variable?

A: Since the states’ volatility in the GEMS Treasury model is proportional to its level, the initial state variables must be non-negative. There are several components of the GEMS’ fitting procedure which ensure that the initial state variables will meet this condition. First, when performing the search algorithm for the best 3 Pivot Points (see slide 5 of the 12/3/20 Treasury Model Presentation), the process will reject any combination that produces one or more invalid state variables. Second, in the very unlikely case that the algorithm is unable to find a valid combination, the process will:

1. pick a combination of Pivot Points
2. convert the initial yield curve into the implied starting states using the inversion process*.
3. shift the invalid state variables to 0.0001
4. calculate the discrepancy curve of the resulting implied Yield curve

*Please see “Appendix II – Initial State Variable Calculation” of the Technical Interest Rate Documentation for more information.

Q2. Are there any boundary conditions on the projected state variables? If so, how does the GEMS model ensure that those boundaries are not violated?

A: Yes, there is a boundary condition requiring that each of the state variables must be non-negative.

There are several components of the formulation that ensure that this condition is met. First, as with the Cox-Ingersoll-Ross model that is the original basis of the GEMS Treasury Model, the projected volatility of each state variable is proportional to its square root. As a result, as a state gets closer to 0, its volatility will drop to zero, which makes it harder to breach zero. Second, a valid calibration of this model requires both the mean reversion level and the mean reversion speed to be positive. Mathematically, this means \( \Theta + \Lambda_0 > 0 \) and \( \kappa - \Lambda_1 > 0 \) for each of the state variables. These conditions ensure that any state variable which gets close to zero will have enough mean reversion so that the simulated values are very unlikely to breach zero. Finally, in the very unlikely scenario that the model does produce a negative state value in the simulation, the procedure will floor the actual value at 0.0001 similar to what the current Academy Interest Rate Generator does for Yields.

Q3. Why aren’t the Lambda parameters used in the Auxiliary functions in the Treasury Targets and Parameters.xlsx file?

A: In terms of the Auxiliary function, the lambda parameters are risk premium adjustments. So, they get used in the mean reversion speed and mean reversion level formulas. However, they do NOT get used in any pricing
formulas. These auxiliary functions are used to price zero coupon bonds (see section 2.2 of the Technical Interest Rate Documentation file).

Q4. What is the purpose of Rows 20-22 of the Auxiliary Functions tab of the Treasury Targets and Parameters.xlsx file?

A: Rows 20-22 are how the Spot Rates are converted into Par Yields. Since the model is arbitrage free, the price of a bond should equal the price of its cash flows. Specifically, for a semi-annual coupon par bond, this means $1 = \text{Price of Par Bond} = \text{Sum(PV of Cash Flows)} = (\text{Coupon} / 2) \times \text{Sum(PV of 1 every 6-months)} + \text{PV of Principal}$. The second component is what we're calculating in Row 21. Rearranging this formula, the Coupon $= 2 \times (1 - \text{PV of Principal}) / \text{Row 21 value}$, which is the formula in Row 22. Since the current Mean-reversion parameter (MRP) values are based on published Treasury Yields, which are expressed as semi-annual Par Yields, this procedure is used to match up the current values.

Q5. What is the foundation of the GEMS’ Treasury model? Is this the same as the current Academy generator?

A: Spot rates form the foundation of GEMS’ Treasury Yield curve construction. Specifically, if you look in the Technical Interest Rate Documentation, there is a formula for the Spot Rate at different tenors based on the current State values on page 5 (under section 2.3 “Initial Yield Curve Fitting”). For context, the 10-Year Spot Rate is based solely on the price of a single cash flow at the end of year 10 (i.e. a 10-Year zero coupon bond). On the other hand, the Academy model starts with Par Yields. In the US, these Yields reflect the semi-annual coupon that a bond would have to pay in order to be priced at Par. These Yields are consistent with the data published on the Federal Reserve’s website. These two methods are related, which is why both models can produce both Spot and Par Yields. Specifically, going from Spot Rates to Par Yields involves solving a series of equations of the form: $1 = \text{Par Value of Bond} = \text{Sum(PV of Fixed Coupons)} + \text{PV of Principal}$ for increasing tenors.

Q6. Which parameters in the GEMS® Treasury model influence the magnitude and frequency of negative interest rates in the projected scenarios?

A: The interaction of several parameters in the GEMS® Treasury model determine the magnitude and frequency of negative interest rates in the projection. First, the shift parameter extends the basic form of the GEMS® Treasury model to allow for the occurrence of negative interest rates. All else equal, the occurrence and magnitude of negative interest rates will increase with more negative values of the shift parameter. Negative interest rates are also influenced by the mean reversion level and the speed of mean reversion. Lower mean reversion targets with slower speeds of mean reversion will produce scenarios with more negative interest rates for longer periods of time in the projection. Additionally, greater volatility will lead to a wider dispersion of scenarios overall, again impacting negative interest rates in the projection.

Finally, although not employed in the 12/18/20 exposure of scenarios, a floor parameter could be added to the model to disallow interest rates below a specified level. Note that the introduction of a floor would cause the GEMS® Treasury model to no longer be arbitrage-free.

Q7. Can you explain the process used to convert the Treasury targets into GEMS parameters?

A: There are several key steps in this process. First, since the Academy model and GEMS are very different, Conning identified either a specific output of the simulations or a characteristic of the model which aligned with the impact that target has on the scenarios. For example, the MRP in the Academy model aligns very closely to the mean long-term 20-Year Par Yield in GEMS. Second, for each of these targets, Conning selected one or more parameters to
adjust which best aligns with this target and is likely to have minimal unanticipated impacts on the simulation. For example, as shown in the equation in section 2.1 of the Technical Interest Rate document, both Kappa and Lambda1 impact the mean reversion speed of the state variables. However, Kappa also affects the projected shape of the Yield curves because it is used in the Affine functions (section 2.2 of that same document). Therefore, Conning chose to adjust the Lambda1 parameters to meet the desired mean reversion speed targets. Finally, Conning developed either a method or a formula to convert the targets into GEMS model parameters. The final result of this process is this table:

<table>
<thead>
<tr>
<th>Target</th>
<th>Characteristic</th>
<th>Parameter(s)</th>
<th>Solution Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overnight Rate</td>
<td>Mean Ultimate 0-Month Spot Rate</td>
<td>Long-Term Target State Variables</td>
<td>Iterative Solution¹</td>
</tr>
<tr>
<td>1-Year Yield</td>
<td>Mean Ultimate 1-Year Par Yield</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRP</td>
<td>Mean Ultimate 20-Year Par Yield</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Reversion Strength for the Slope²</td>
<td>Mean Reversion Speed of the state variable with the largest Kappa³</td>
<td>Lambda1 for the associated state variable</td>
<td>Since the Mean Reversion speed is 1 / (Kappa – Lambda1) (see section 3), Lambda1 = Kappa – 1 / Mean Reversion Speed.</td>
</tr>
<tr>
<td>Mean Reversion Strength for the Log of the Long-Term Rate²</td>
<td>Mean Reversion Speed of the state variable with the smallest Kappa³</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Mean Reversion Speed of the final state variable⁴</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Target State Variables</td>
<td>N/A</td>
<td>Lambda0 for the associated state variable</td>
<td>Since the Mean Reversion level is (Theta + Lambda0) * Mean Reversion Speed (see section 3), Lambda0 = Target / Mean Reversion Speed - Theta.</td>
</tr>
</tbody>
</table>

¹ For the Long-Term Target State Variables, the nature of the problem ensures that there will be a unique solution: we have three equations with three unknowns. However, the math is too complicated to solve analytically since the Affine formulas give us Spot Yields while the longer targets are expressed as Par Yields. Therefore, Conning will simply use a search algorithm to find the unique solution.

² The Mean Reversion Strengths in the current Academy model are expressed on a monthly basis. To convert those into the speed targets GEMS needs (i.e., annual), Conning calculated 1 / (1 – (1 – Academy’s Mean Reversion Strength) ^ 12)).

³ Within GEMS, the Kappa value affects the shape of the B(T) function which get multiplied by the state variables to calculate the final Spot Yields (see section 2.2 of the Technical Interest Rate document). When Kappa is close to zero, this curve becomes essentially flat. In that case, a 1% movement in the corresponding state value will lead to a roughly 1% parallel shift in the Spot curve. This aligns very well with how the Long-Term Rate impacts the current Academy model’s simulations. With a higher Kappa, the B(T) curve becomes very steep. So, a 1% move in this associated state variable will move the short end of the curve about 1%, but have very little impact on the long end of the curve. This behavior aligns well with how the slope impacts the current Academy model’s simulations.

⁴ In the Baseline proposal, this target was set to the (Mean Reversion Speed for the first state variable) * (Mean Reversion Speed for second state variable / same quantity for the first state variable in GEMS standard calibration).

For an example of how this works, please refer to the Treasury Targets and Parameters Excel worksheet.
Section B: Equity Model

Q1. How are the international fund returns expressed: hedged or unhedged?

A: The international funds are in USD and are presented on an unhedged basis. The AAA ESG also expresses international fund returns on an unhedged basis.

Q2: On the February 25th LATF call, it was mentioned that over longer projection periods the wealth factors for equity indices will be roughly lognormal despite the jump parameters (slide 13). Can you please explain the reason for this?

A: This is a consequence of the Central Limit Theorem (CLT). Based on that Theorem, if \( X_i \) are independent samples from the identical distribution, then \( \sum X_i \) converges to a normal distribution regardless of the distribution of the \( X_i \). A corollary of that theorem is that if \( Y_i \) are independent samples from the identical strictly positive distribution, then \( \prod Y_i \) converges to a lognormal distribution. To see that, we use the transformation \( Y_i = \exp(X_i) \). Then, \( \prod Y_i = \prod \exp(X_i) = \exp(\sum X_i) \) since the \( X_i \) are independent if the \( Y_i \) are independent. Finally, if \( \sum X_i \) converges to a normal distribution, then \( \exp(\sum X_i) \) converges to a lognormal one.

Now the key question: how does that apply to the wealth factor for equity indices? First, the wealth factor at the end of a simulation is \( \prod (1 + \text{Return}_i) \) across the simulation. As long as the Return can’t be less than -100%, which is the case for the equity returns in GEMS, we can let \( Y_i = 1 + \text{Return}_i \) in the above discussion. Then, the only question is whether or not these \( Y_i \) meet the other conditions of this Theorem. In Figure 1, we can see that the standard deviation for the Large Cap index is fairly stable over the 30-year projection period. Plus, the volatility reverts to long-term levels very quickly. As a result, these equity returns are close enough to being identically distributed that they will meet one of the weak forms of the CLT.\(^1\) By comparison, the Money Market returns have dramatic shifts in their cross-sectional volatility (see the Revised Baseline Fan Charts for an example): the returns in year 30 are almost 5 times as volatile as the returns in year 1. Therefore, the Money Market returns will take longer to converge.
Second, we need to consider independence. Under the CLT under weak dependence extension, we really just need the returns to have very little serial correlation. From Figure 2, we can see that this is the case for the Large Cap returns coming out of the GEMS model across the entire simulation period: the year over year serial correlation is never beyond +/-5%. As a result, we can expect fairly rapid conversion of the Large Cap asset class’ wealth factor to a lognormal distribution. Money Market returns, on the other hand, have a serial correlation that approaches 1 in the later projection years. This is because the Money Market returns in later years are largely driven by the simulated short-term Treasury Yields. Since the 3-Month Treasury Yield at the end of the 28th simulation period is
highly correlated to the one at the beginning of the 29th, we see very high serial correlation in this asset class. Once again, this means the Money Market asset class’ wealth factor may never converge to a lognormal distribution.³

![Serial Correlation by Projection Year](image)

**Figure 2:** Serial correlation across time based on the Baseline calibration released on February 24, 2021 for selected Asset Classes

1 Since the GEMS model links equity returns to short-term Treasury Yields, the expected returns will change over the projection period as Treasury Yields revert to their long-term targets. However, differences in means have no impact on the conversion process.


3 Despite the many differences between GEMS and the current Academy models, all of these same results would apply to the current Academy model for both Large Cap and Money Market returns.

**Q3:** In the Revised Baseline scenarios posted on February 24, 2021, the wealth factors for some of the equity returns are quite extreme. For example, the maximum return at the end of the 30-year projection period for the Large Cap asset is over 14,600% while the minimum is -97.6%. Is this something that could be controlled through the model parameterization?

**A:** These values are almost entirely driven by the expected mean and standard deviation of the annual returns for this index. For comparison purposes, the corresponding values from the current Academy model for this index are about 19,400% and -53% based on the December, 2019 model. However, the Academy model has an average cumulative return that is roughly 47% higher, or roughly 1.3% per year¹. If we adjust the Academy returns by this difference, then the corresponding values would be roughly 13,200% and -68%. The majority of the remainder of the difference is due to the fact that the GEMS returns are about 1.5% more volatile (i.e. 17.5% vs 16% annual

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¹ Since the GEMS model links equity returns to short-term Treasury Yields, the expected returns will change over the projection period as Treasury Yields revert to their long-term targets. However, differences in means have no impact on the conversion process.


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standard deviation). As described in Q2 above, these returns end up being fairly close to lognormal, as can be seen in Figure 3.

![Cumulative 30-Year Total Return Q-Q Plot](image)

**Figure 3**: Comparison of simulated percentile distribution for the GEMS and Academy models’ Large Cap wealth factor and the corresponding values from a lognormal distribution (i.e. the dotted line).

So, what would have to change in the model structure to alter these extremes? As mentioned above, the returns at the extreme tails are largely influenced by the targets for the expected mean and standard deviation. About the only other items that could be tweaked would be to add negative serial correlation for these projections, at least of the magnitude of those seen for the Long Govt index in Figure 2. With that adjustment, the cumulative returns would grow slower than those in the Revised Baseline model. However, the historical data on which this index is built does not indicate that such an adjustment is in line with the data (see Figure 4).
Figure 4: Serial correlation of annual returns of different rolling 30-year calendar years. For example, the 2015 figure is based on the 30 annual S&P 500 total returns from December 1985 through December 2015.

1 The average annual Large Cap return from the AIRG is 8.3%. The corresponding value for the Revised Baseline GEMS Scenarios is 7.2%.

2 With no serial correlation, the cumulative return’s volatility grows with, roughly, the square root of time. With positive serial correlation, like those for Money Markets, they grow faster than that. With negative serial correlation, they will grow slower.

Section C: Corporate Model

Q1. Why are bond funds assumed to only invest in industrials (not financials)?

A: One of the goals of the bond funds was to make them consistent with the data being included in the Robust Data set. Since that data set is only going to include one set of Corporate Yields, which will be for industrials, we are suggesting only using these bonds for the bond fund returns.

Q2. Do BBB bonds in the U.S. Investment Grade Corporate bond fund returns reflect a selected BBB bond, a universe of BBB+ / BBB / BBB- bonds, or some other blend of bonds?

A: For any of the Corporate ratings, the bonds will be issued exactly at that rating (i.e. only BBB bonds in this case). The returns will reflect a broadly diversified set of bonds of the selected rating and maturity.
Q1. What is the purpose of the Scenario Reduction Tool referenced in item #9 of the ESG Implementation Timeline?

A: Conning will deliver a full set of 10,000 economic scenarios on a monthly basis along with scenario subsets produced using the Scenario Reduction Tool that is eventually adopted. The purpose of the Scenario Reduction Tool is to select subsets from the full set of 10,000 that are representative of the full set. A proposal to follow the American Academy of Actuaries’ scenario picking methodology has been exposed for public comment through March 7th, 2021. See the link below for more details.

ESG Scenario Picker Tool

Q2. What is the GEMS® API?

A: The GEMS® API (Application Programming Interface) will offer companies an alternative way to generate data in either the Basic or Robust Data Sets. The API code can be incorporated directly into third-party software to allow for faster processing of the data and a more tailored workflow. This will allow users more flexibility in the number of scenarios and projection length in their simulation process. The GEMS® API is available for a fee from Conning.

Q3. Does the API accept a starting Yield Curve or is it fed the initial state variables?

A: Right now, the API starts with the initial state variables. An enhancement to the API to accept the starting yield curve as input is planned.

Q4. Does the GEMS API support dynamic generation of forward-starting inner loop scenarios, based on a user-specified outer loop scenario Yield curve at that future projection period?

A: Yes, the GEMS API can be configured to produce inner loop scenarios based on a user-supplied outer loop scenario Yield curve.

Section E: ESG Field Test

Q1. Our company would like to volunteer to participate in the field test. How can we sign up?

A: Companies wishing to participate in the field test should contact Reggie Mazyck by March 1st, 2021 at rmazyck@naic.org and provide the following information:

- Company name
- NAIC company code
- Names and email addresses of company contacts
- A list of the product types the company intends to include in the field test

More information is provided in this document: ESG Field Test Request

Q2. What is the scope of the ESG field test?

For both Variable Annuity (VM-21 and C3P2) and Life (VM-20) business, it seems that the new ESG directly replaces the existing prescribed AirG parameterization. However, for fixed annuities (C3P1) there will be additional methodology considerations as the new ESG will not necessarily act as a direct substitute for the one that is currently prescribed. For example:
C3P1 currently uses a special 12 or 50 scenario subset designed to approximate 95%-tile interest rate risk. Would new subsets be developed, or would Conning’s 200 scenario set be used directly?

C3P1 currently prescribes only the interest rate scenarios. Would prescribing GEMS mean that equity scenarios also become prescribed? This would expand the scope of C3P1 to both interest rate and market risk.

- Some companies currently use a deterministic equity scenario with the prescribed C3P1 interest rates scenarios.
- If C3P1 were expanded to cover market and interest rate risk, it seems like we’d need to split the total, similarly to how C3P2 needs to be split.
- In addition, if stochastic equity returns were applied to inforce general account assets (e.g., alternative assets like hedge funds and private equity), would there be a double count with asset risks covered by C-1?

A: The scope is expected to include VA (VM-21 and C3P2), and Life (VM-20), with the new ESG directly replacing the existing prescribed AIRG parameterization. For C3P1, the methodology needs to be considered, along with field test timing, given the developments on VM-22. For now, please assume C3P1 is in scope for field testing. This will give regulators an indication of the level of participation for companies with products subject to C3P1.

Section F: Scenario File Form and Format

Q1. Once the new ESG is in production, how will scenario files be accessed?

A: Conning will produce scenarios from the Basic Data Set as of each month-end and post them to the ESG landing page on Conning’s website by 4:00 PM Central Time on the first business day of the following month. The ESG landing page on Conning’s website can be accessed by clicking the link in the “Economic Scenarios” section of the NAIC’s PBR webpage. This will be different than the prior process employed by the American Academy of Actuaries, where an excel tool was made available for users to generate scenarios on demand.

Q2. The scenario file is very large and doesn’t have the same format as the Academy scenarios. Can this be changed?

A: Yes. Please provide feedback with specifics on how you would like the output to be provided.

Q3. The 12/18/20 exposure only includes 30 projected years of economic scenario data. Is it possible to produce economic scenario files with a longer projection period?

A: Yes. Please provide feedback on the projection period desired for the scenario data. Please note that the GEMS software can generate an unlimited number of periods.

Q4. The International Diversified Equity (MSCI EAFE) and Aggressive Foreign Equity (MSCI Emerging Market) do not have Income Returns in the sample data set. Will this be split between price and income in the future?

A: The model only projected total returns for these indices. Conning is developing an alternative calibration for these two indices which will split their total returns into Price and Income.

Q5. Is the scenario file labeled “Initial Exposure thru Jan 2021 GEMS Output for Dec 2019” considered to be the “Basic Data Set”?

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A: Yes. The contents of the Basic Data Set are summarized in the “Basic Data Columns” file. The comment period for the exposure has been extended to March 7, 2021. The initial set of scenarios represent a first cut at the types of changes that may be desired for the ESG. Additional modifications are expected based on comments received.

Q6. There are 10,000 scenarios included in the 12/18/20 exposure. Is there a simple way to extract a smaller set of scenarios from this file?

A: If you would like to look at a smaller sample, you can just use a portion of the file (e.g. the first 1000 scenarios). The time periods for each scenario are in order, so 1,000 scenarios would be the first 36,000 rows of data. This is different from the scenario selection process exposed on 1/21/21, but it will allow you to look at a representative subset. If you are interested in just the characteristics of the scenarios, you may also be interested in the Initial Exposure Full GEMS Fan Charts on the site. That is a PDF summary for each of the columns across the full 10,000 scenarios and 360 months.

Section G: Calibration and Parameter Updates

Q1. How often will the parameters of the model be updated?

A: This is to be determined and is included as item #8 on the ESG timeline.

Q2. What will the governance process be for monthly scenario releases, routine changes to the ESG calibration, and more structural changes to the ESG model?

A: This is to be determined and will be addressed as part of items #8 and #25 on the ESG timeline.

Q3. Will calibrated parameters of the GEMs model be published?

A: The expectation is that the parameters will be published. There will also be formulas published which link the target parameters, such as the MRPs, to the GEMS’ model parameters.

Q4. Will the data used for each calibration be publicly available?

A: Every attempt will be made to use public information. However, when that is not possible, Conning will release the Bloomberg ticker, or other appropriate indicators, for the source of the data.

Q5. Will a spreadsheet tool be made public that replicates the new algorithms used to develop the scenarios?

A: No. While some components of the model will be documented via spreadsheets, such as the Treasury Targets and Parameters.xlsx file that was included in the Exposure Draft, those interested in generating the scenarios directly should contact Conning about either the GEMS API or software.

Section H: Documentation

Q1. What is the plan for releasing additional documentation on the Treasury, Equity, and Corporate models?

A: Conning has produced initial documentation for the Treasury, Equity, and Corporate models. This documentation can be accessed by clicking the link under the “Economic Scenarios” section of the NAIC’s PBR.
Webpage. More information will be added to the documentation throughout the project as it evolves. Specific requests for additional items to cover in the documentation can be made to Reggie Mazyck at the NAIC.

Section I: 12/17/20 LATF Equity and Corporate Model Presentation

Q1. On page 13, are the 2 year and 30 year “columns” annualized returns?

A: No, those are summaries of the total return over the associated year. For example, the values in the second column reflect a summary of the 10,000 total returns from Sept 2021 through Sept 2022 from the current AIRG model.

Q2. On page 18, are the 34 negative thirty year returns for GEMS, and 3 for the AIRG, out of 10,000 scenarios? One would expect about 50 negative returns for the AIRG, if it is for 10,000 scenarios.

There have been no negative 30-year periods for the S&P 500, even if you include the Great Depression. There are some good reasons to exclude the Great Depression from consideration for S&P 500 returns. The S&P did not become 500 stocks until 1957, being only 90 stocks from 1929 until 1957. SEC rules and other governance and advances in understanding of economics provide greater information and protection for investors than existed in the 1920’s and 1930’s. Comparisons to those periods might be more appropriate for some of the smaller and less well diversified indices in the scenarios.

A: Yes, both of those counts are out of 10,000 scenarios. These were scenarios selected where the cumulative return was below 0 for all 30 years of the simulation. So, it is a subset of the ones that end the simulation below zero.

Q3. How are the correlations on page 22 being computed?

A: For those correlations, we first sorted the relevant scenarios (i.e. rolling 12-month periods for the historical data, the 10,000 scenarios for the first year for the simulations) based on the US Large Cap (i.e. S&P 500) total return. Next, we broke that data down into 5 equal quintiles. So, for the GEMS scenarios, the ones in the 1st quintile reflect the 2000 scenarios with the smallest US Large Cap total returns. Finally, the bars reflect the correlation between the US Large Cap and US Small Cap (i.e. Russell 2000) within these quintiles.

Section J: 12/18/20 LATF Exposure

Q1. Scenarios were provided as of 12/31/19. Can they be provided as of 9/30/20 or 12/31/20?

This would be useful given lower starting rates than 12/31/19, and the scenarios could use the 3.25% 20-year mean reversion target for UST.

A: Yes. However, we expect to improve the model calibration and provide a new set of scenarios based on comments received on the 12/18/20 exposure. We propose to wait until then to provide scenarios as of different dates.

Q2. In the target formulas shown in the Targeting Example.xlsx file included in the 12/18/20 exposure, it looks like Theta and Lambda0 get added together in the targets. Why are there two separate parameters?
A: For the Long-Term State value targets (i.e. Column J of the Model Parameters tab of Targeting Example.xlsx file), the formula does add together Theta and Lambda0. A similar manipulation happens with the Kappa and Lambda1 parameters: those same formulas use the difference between these two parameters. Both Lambda0 and Lambda1 are risk premium parameters. Specifically, they are the ones which allow the long-term reversion levels for Yields to differ from those implied by the initial Yield curve. Whenever the model needs to price a set of cash flows (e.g. determining a particular Spot Rate), it does NOT use these risk premiums. That is why all of the formulas on the Auxiliary Functions tab of that spreadsheet, which are used to determine spot rates at different tenors, only reference parameters from the Theta, Kappa, and Sigma columns. This is also why there are two separate parameters: one that gets used for pricing (i.e. Theta and Kappa) and one that gets used as a risk premium (i.e. Lambda0 and Lambda1).

For more information, see the Treasury Model documentation.

Q3. Do the mean reversion level and speed in the Risk-Neutral model impact the scenarios in the Real-World model?

A: No, the Real-World model only relies on the mean reversion characteristics of the Real-World model, just like the current Academy generator.

Section K: Governance

Q1. What is the LATF ESG exposure, testing, and approval process?

Please explain the process for:

- Regularly scheduled / routine updates beyond initial condition or formulaic updates (E.g., bringing an additional year of historical data into the calibration), and
- More fundamental model changes (e.g., structural changes, changes in calibration methodology / philosophy).

A: The governance process is to be determined and will be addressed as part of items #8 and #25 on the ESG timeline.
<p>| Item # | Issue | Source | Question | Addressed? | Type | Question 1 | Question 2 | Question 3 | Question 4 | Question 5 | Question 6 | Question 7 | Question 8 | Question 9 | Question 10 | Question 11 | Question 12 |
|-------|-------|--------|----------|-----------|------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| 1     | ACLI  | ACLI   | What criteria did apply when selecting/developing their ESG (a) Goals; (b) Model Selection Rules? | No        | No   | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      |
| 2     | ACLI  | ACLI   | What does the relationship of scenario outputs and on an ongoing basis? | No        | No   | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      |
| 3     | ACLI  | ACLI   | Distribution: A. What pros/cons when selecting/developing their ESG (a) Goals; (b) Model Selection Rules? | No        | No   | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      |
| 4     | ACLI  | ACLI   | Distribution: B. How does the relationship of scenario outputs and on an ongoing basis? | No        | No   | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      |
| 5     | ACLI  | ACLI   | Distribution: A. What pros/cons when selecting/developing their ESG (a) Goals; (b) Model Selection Rules? | No        | No   | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      |
| 6     | ACLI  | ACLI   | Distribution: B. How does the relationship of scenario outputs and on an ongoing basis? | No        | No   | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      |
| 7     | ACLI  | ACLI   | Distribution: A. What pros/cons when selecting/developing their ESG (a) Goals; (b) Model Selection Rules? | No        | No   | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      |
| 8     | ACLI  | ACLI   | Distribution: B. How does the relationship of scenario outputs and on an ongoing basis? | No        | No   | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      |
| 9     | ACLI  | ACLI   | Distribution: A. What pros/cons when selecting/developing their ESG (a) Goals; (b) Model Selection Rules? | No        | No   | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      |
| 10    | ACLI  | ACLI   | Distribution: B. How does the relationship of scenario outputs and on an ongoing basis? | No        | No   | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      |
| 11    | ACLI  | ACLI   | Distribution: A. What pros/cons when selecting/developing their ESG (a) Goals; (b) Model Selection Rules? | No        | No   | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      |
| 12    | ACLI  | ACLI   | Distribution: B. How does the relationship of scenario outputs and on an ongoing basis? | No        | No   | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      | ACLI      |</p>
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**Conning Tang**

- **Question No 13**: [Describe the] out of the box capabilities in GEMS to allow different relationships (vs. just substituting different parameter values)?
  - **Question**: No

- **Question No 15**: What would actually change on a monthly basis?
  - a) Conning only updating initial conditions (and any LATF-specified formulaic updates – e.g., MRP)?
  - b) Are the updates purely mechanical, or are there any subjective tweaks or judgment calls?
  - **Question**: No

- **Question No 16**: What is the LATF exposure / testing / approval process for:
  - a) Other regularly scheduled / routine updates beyond initial condition or formulaic updates (e.g., bringing an additional year of historical data into the calibration)?
  - b) More fundamental model changes (e.g., structural changes, changes in calibration methodology / philosophy)?
  - **Question**: Yes

- **Question No 17**: What is the process for something unexpected / unanticipated happens in the monthly updates (e.g., routine business as usual) update/create scenarios that suddenly don’t make sense, or the calibration produces invalid parameters?
  - a) What is the process for reviewing and detecting questionable or inappropriate scenario distribution properties before scenarios are posted? (There should be checks for reasonability of distribution properties and not just validation that specific targets were reproduced. The scenarios exposed in Dec. reproduced LATF’s / Conning’s intended targets, but the process should have identified the inappropriate distribution of yield curve shapes.)
  - b) What is the escalation process if issues are detected? (Does Conning make judgments on their own? Are regulators and industry at risk of being surprised when unusual scenarios produce unusual reported results or changes in reported results that don’t align with prior sensitivities/dynamics?)
  - **Question**: To be addressed as part of item #8 in the ESG timeline.

- **Question No 18**: The International Diversified Equity (MSCI EAFE) and Aggressive Foreign Equity (MSCI Emerging Market) do not have Income Returns in the sample data set. Will this be adjusted to align with the historical results for these indices?
  - **Question**: No

- **Question No 19**: Why are bond funds assumed to only invest in industrials (not financials or industrials)?
  - **Question**: Yes

- **Question No 20**: Do BBB bonds reflect a selected BBB bond, a universe of BBB+ / BBB / BBB- bonds, etc.?
  - **Question**: Yes

- **Question No 21**: How are the international fund returns expressed: hedged or unhedged?
  - **Question**: Yes

- **Question No 22**: How often will the parameters of the model be updated?
  - **Question**: Yes

- **Question No 23**: See “Conning Tang” tab
  - **Question/Comment**: No

- **Question No 24**: How are the jump parameters determined and/or set? Does the model reflect recent jump data or long-term averages or a combination of both? Looking at historical data, how does the model determine when a jump has occurred and the magnitude of the jump? For example, considering the movement in the S&P 500 during the first couple of quarters of 2020, was this considered a jump or multiple jumps? If so, what was the criteria used to determine if a jump occurred? Over how many days was the jump considered to occur and what was the magnitude of the jump?
  - **Question**: Yes

- **Question No 25**: How is the value of the mean reversion speed parameter in the Variance Equation determined?
  - **Question**: Yes

- **Question No 26**: On page 13 [of the 12/17/20 LATF Equity and Corporate Model Presentation], are the 2 year and 30 year “columns” annualized returns?
  - **Question**: Yes

- **Question No 27**: On page 18 [of the 12/17/20 LATF Equity and Corporate Model Presentation], are the 34 negative thirty year returns for GEMS, and for the AIRG, out of 10,000 scenarios?
  - **Question**: Yes

- **Question No 28**: In the target formulas, it looks like Theta and Lambda0 get added together in the targets. Why are there two separate parameters?
  - **Question**: Yes

- **Question No 29**: Does that imply that the mean reversion speed and level of the embedded risk neutral model (i.e. the model without Lambda0 and Lambda1) doesn’t impact the scenarios?
  - **Question**: Yes

- **Question No 30**: Are there any boundary conditions on the state variables? If so, how does the GEMS model enforce that those boundaries are violated?
  - **Question**: Yes

- **Question No 31**: See “Mark Tenney 3.8.21” tab
  - **Question**: No

- **Question No 32**: Does the API accept a starting Yield Curve or is it fed the initial state variables?
  - **Question**: Yes

- **Question No 33**: Does the GEMS Treasury model require the initial state variables to be non-negative? If so, what happens if the initial yields produce a negative state variable?
  - **Question**: Yes

- **Question No 34**: See “Moody’s Analytics’ Questions” tab
  - **Question**: No

- **Question No 35**: Will scenarios be consistent from month to month? In other words, will new scenario number 1 be comparable to old scenario number 1 or will the scenarios be an entirely new random set? We would like to see consistency from period to period.
  - **Question**: Yes

- **Question No 36**: When parameters are updated, will Conning provide scenarios as of the valuation date before and after changing each parameter? Before and after changing all parameters in aggregate? We would like to be able to assess the impact of the change of each parameter.
  - **Question**: No

- **Question No 37**: If 10,000 scenarios are not enough for convergence (particularly for CTE98), what do we do?
  - **Question**: No
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<th>Yes/No</th>
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<tr>
<td>38</td>
<td>Scott Schneider</td>
<td>What time steps will be available (daily, weekly, monthly, quarterly, annual) within the scenarios? How many years of projection will be provided in each scenario? We would like the ability to get time steps of any frequency from daily to annual. We would also like 90 years' worth of time steps.</td>
<td>Yes</td>
<td>ESG Q&amp;A, Section F, Q7</td>
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<td>39</td>
<td>Scott Schneider</td>
<td>Will individual states (e.g., New York) have different requirements? We would like the scenarios to be provided with and without individual state requirements.</td>
<td>No</td>
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<td>Scott Schneider</td>
<td>We believe that Conning has stated that the interest rate generator (GEMS) is arbitrage-free, but the equity return generator appears to add a positive risk premium resulting in scenarios which are not arbitrage-free. Is our understanding correct? If so, will there also be an arbitrage-free version of the equity scenarios?</td>
<td>Yes</td>
<td>ESG Q&amp;A, Section B, Q6</td>
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<td>41</td>
<td>Seong-min Eom</td>
<td>I propose the scenarios listed below for public comments and review. •The new revised scenario •Higher Volatility •Alternative Shift •Alternative Start Date If we can combine multiple revisions, I suggest adding Higher Volatility with Alternative Shift.</td>
<td></td>
<td>Posting to naic.conning.com/scenariofiles 2/4/2021</td>
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<td>42</td>
<td>Seong-min Eom</td>
<td>In the scenario statistics, I want to suggest adding maximum and minimum in the fan chart (already shown in the summary table) and providing volatility distributions. Also want to have correlations between credit and interest rates, between credit and equities, and between equity funds.</td>
<td>Pending</td>
<td>New set of Fan Charts</td>
</tr>
<tr>
<td>43</td>
<td>Steve Tizzoni</td>
<td>Please describe the process through which current @ valuation date) equity volatility of SERT targets, with a focus on the speed and strength of the reversion process.</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>Steve Tizzoni</td>
<td>We appreciate the sensitivities that were recently performed and summarized on the NAIC website. Would it be possible to receive the raw scenario output for the 12/31/2020 scenario set?</td>
<td>Yes</td>
<td>naic.conning.com/scenariofiles</td>
</tr>
<tr>
<td>45</td>
<td>Tim Finnegan</td>
<td>Q&amp;A Section F Q3: # of projected periods for scenarios For most stochastic projections we prefer at least 40 years of stochastic scenarios. For certain product line testing, 65 year projections are used.</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Tim Finnegan</td>
<td>Related: SERT scenarios The exposed set of SERT scenarios extended for 30 years. We feel the projection period output for SERT scenarios needs to be even longer than what is reasonable for most stochastic projections because a section of VM-20 calls for projecting &quot;cash flows for a period that extends far enough into the future so that no obligations remain.&quot; For this purpose, a 100 year projection period should suffice.</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>Vincent Tsang</td>
<td>In the graph &quot;Equity Equation – Impact of Jumps&quot; on page 10 of the ppt slides, the projected cumulative wealth factors from AIRG and GEMS at the end of the 30th year can be approximated by the line AIRG cumulative wealth factor = 1.3082 (GEMS cumulative wealth factor) + 1.4558 For example, if GEMS cumulative factor is 4500%, the AIRG cumulative factor is approximately 6000%. Please explain the driver(s) which cause AIRG's cumulative wealth factor being significantly higher than GEMS's cumulative factor. Given that the title of the slide is &quot;Equity Equation – Impact of Jumps,&quot; is the difference in wealth factors attributable to the assumed jumps? If not, why?</td>
<td>Yes</td>
<td>ESG Q&amp;A, Section B, Q4</td>
</tr>
<tr>
<td>48</td>
<td>Vincent Tsang</td>
<td>In the first page of the ppt slides &quot;Equity Equation,&quot; the differential equation is listed as follow: [ ds(t) = \frac{1}{\mu} \left( v(t) - \lambda \right) dt + \mu \sigma \left( v(t) - \lambda \right) dW ] As the jump parameters ( \lambda ) and ( v(t) ) are positive and ( m ) is negative in page 8, the drifting factor due to the jump parameters is negative. Does it mean that the jump parameters would reduce the drifting factor for the equity return?</td>
<td>Yes</td>
<td>ESG Q&amp;A, Section B, Q5</td>
</tr>
</tbody>
</table>
The Life Actuarial (A) Task Force met Feb. 25, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Judith L. French, Vice Chair, represented by Jason Wade (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li and Steve Ostlund (AL); Ricardo Lara represented by Ben Bock and Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); Scott A. White represented by Craig Chupp (VA); and James A. Dodrill represented by Tim Sigman (WV).

1. **Discussed General ESG Updates**

Pat Allison (NAIC) provided an update on the economic scenario generator (ESG) project. She said the landing page on the Conning & Company (Conning) website has been revised to facilitate access to ESG documentation. She said 23 companies have volunteered so far to participate in the ESG field test. She said participation requests will be accepted beyond the March 1 deadline. She said the question-and-answer (Q&A) document and technical documentation are available on the Conning website.

2. **Heard a Presentation on the Equity Model from Conning**

Daniel Finn (Conning) presented a slide deck (Attachment Three-A) on the GEMS equity model. He said the basic dataset provides equity indices for small cap, mid-cap, large and aggressive U.S equities. He discussed the following items related to equity returns: 1) risk premium parameters; 2) variance parameters; 3) jump parameters; and 4) dividend parameters. He noted that the calibration methodology looks at recent equity price changes over the period leading up to the model start date.

3. **Received an Overview of the Recent Exposures**

Scott O’Neal (NAIC) provided an overview of the list of ESG documents (Attachment Three-B) that the Task Force chair exposed on Feb. 24. The exposures are available on the Exposure tab of the Task Force website for public comment through March 22. The documents are also available on the Conning website.

The recording of the virtual meeting is available on the Related Documents tab of the Task Force website.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Overview of GEMS® Equity Model Formulae and Parameters
Feb. 25, 2021
Dan Finn, FCAS, ASA – Managing Director at Conning

Agenda

1. Equity Model Equations
2. Risk Premium Parameters
3. Variance Parameters
4. Jump Parameters
5. Dividend Parameters
Equity Equations

\[ \frac{dS(t)}{S(t)} = [(r(t) - D(t)) + \mu_0 + \mu_1 V(t) - \lambda_m V(t)]dt + \sqrt{V(t)}dW_1(t) + \gamma dN(t) \]

\[ dV(t) = (\alpha - \beta V(t))dt + \sigma \sqrt{V(t)}dW_2(t) \]

\[ dD(t) = \kappa (\beta D - \lambda D(t))dt + \sigma_D \sqrt{D(t)}dW_3(t) + D(t)\gamma dN(t) \]

Where:

- \( r(t) \) is the short rate simulated by the interest rate model
- \( D(t) \) is the stochastic dividend yield
- \( \mu_0 \) and \( \mu_1 \) are risk premia
- \( V(t) \) is the stochastic variance
- \( N(t) \) is a Poisson counting process with intensity \( \lambda_1 V(t) \) which is shared by the price and dividend processes
- \( \gamma \) is a variable jump size
- \( m \) is the average of the variable jump size \( \gamma \)
- \( \beta \) is a parameter controlling the mean reversion speed of the variance process
- \( \kappa \) is a parameter controlling the mean reversion speed of the variance process
- \( \sigma \) is the instantaneous variance of the variance process
- \( \sigma_D \) is the instantaneous variance of the dividend process
- \( \gamma_0 \) is the variable jump size of the dividend process

Easiest to break it down into our categories:

1. Risk Premium Parameters
2. Variance Parameters
3. Jump Parameters
4. Dividend Parameters
Equity Equations

Easiest to break it down into our categories:

1. Risk Premium Parameters

<table>
<thead>
<tr>
<th>Risk Premium Parameters</th>
<th>Large Cap</th>
<th>Mid Cap</th>
<th>Small Cap</th>
<th>Aggressive US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed Return ($\mu_0$)</td>
<td>0.05193343</td>
<td>0.054419634</td>
<td>0.058658186</td>
<td>0.065662379</td>
</tr>
<tr>
<td>Risk Premium Coefficient ($\mu_1$)</td>
<td>0.092564524</td>
<td>0.001976953</td>
<td>0.001216322</td>
<td>0.018593352</td>
</tr>
</tbody>
</table>

Equity Returns

![Image of US Equity Total Return](chart)
Equity Equations

Easiest to break it down into our categories:

1. Risk Premium Parameters
2. Variance Parameters

<table>
<thead>
<tr>
<th>Risk Premium Parameters</th>
<th>Large Cap</th>
<th>Mid Cap</th>
<th>Small Cap</th>
<th>Aggressive US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Value</td>
<td>0.010408794</td>
<td>0.014820659</td>
<td>0.015796296</td>
<td>0.018894151</td>
</tr>
<tr>
<td>Alpha (α)</td>
<td>0.00556428</td>
<td>0.004701873</td>
<td>0.004907813</td>
<td>0.008586708</td>
</tr>
<tr>
<td>Beta (β)</td>
<td>0.396577448</td>
<td>0.261910925</td>
<td>0.278360478</td>
<td>0.307103203</td>
</tr>
<tr>
<td>Sigma (σ)</td>
<td>0.081871925</td>
<td>0.077045982</td>
<td>0.096470077</td>
<td>0.090934214</td>
</tr>
</tbody>
</table>

Equity Returns

**US Equity Total Return**
Year 30 of Simulation

![Graph of US Equity Total Return](image)
Equity Returns – Impact of Treasury Calibration

Equity Equations

Easiest to break it down into our categories:
1. Risk Premium Parameters
2. Variance Parameters
3. Jump Parameters

<table>
<thead>
<tr>
<th>Risk Premium Parameters</th>
<th>Large Cap</th>
<th>Mid Cap</th>
<th>Small Cap</th>
<th>Aggressive US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable Jump Intensity</td>
<td>139.5881991</td>
<td>113.4167777</td>
<td>112.9783715</td>
<td>128.7243452</td>
</tr>
<tr>
<td>Jump Size Mean (m)</td>
<td>-0.052498034</td>
<td>-0.042004029</td>
<td>-0.069631949</td>
<td>-0.050422735</td>
</tr>
<tr>
<td>Jump Size Volatility</td>
<td>0.0575</td>
<td>0.05749</td>
<td>0.057488</td>
<td>0.05949</td>
</tr>
</tbody>
</table>
Equity Equation - Impact of Jumps

S&P 500 Total Return
3Q 2020

Equity Equation - Impact of Jumps

Cumulative 30-Year Wealth Factor
GEMS vs AIRG

y = 1.3082x + 1.4558
Equity Equation - Impact of Jumps

![Cumulative 30-Year Total Return Q-Q Plot](image)

Equity Equations

Easiest to break it down into our categories:

1. Risk Premium Parameters
2. Variance Parameters
3. Jump Parameters
4. Dividend Parameters

<table>
<thead>
<tr>
<th>Risk Premium Parameters</th>
<th>Large Cap</th>
<th>Mid Cap</th>
<th>Small Cap</th>
<th>Aggressive US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha ( (\alpha_a) )</td>
<td>0.013265383</td>
<td>0.008360257</td>
<td>0.01212561</td>
<td>0.006587937</td>
</tr>
<tr>
<td>Kappa ( (\kappa_a) )</td>
<td>0.461711897</td>
<td>0.330378827</td>
<td>1.149459043</td>
<td>0.550540254</td>
</tr>
<tr>
<td>Theta ( (\theta_a) )</td>
<td>0.005172487</td>
<td>0.045636438</td>
<td>0.001348106</td>
<td>0.066856412</td>
</tr>
<tr>
<td>Sigma ( (\sigma_a) )</td>
<td>0.030871345</td>
<td>0.020316506</td>
<td>0.047428824</td>
<td>0.019789501</td>
</tr>
</tbody>
</table>
**ESG Comment Period Extensions**

Please note that the comment period for all previous ESG exposures has been extended to **March 22nd, 2021**. Comments received on all the ESG exposures will be discussed at the Spring NAIC National Meeting LATF session on April 8th, 2021.

**ESG Exposure 2/24/21: Alternative Treasury Calibrations**

The items listed below are exposed for a public comment period ending on **March 22nd, 2021**.

**LATF ESG Exposure 2.24.21 for Revised Baseline Calibration – exposed for comments through 3.22.2021**

Regulators and the NAIC have received feedback on the 12/18/20 exposure of an initial set of proposed ESG parameters and associated economic scenarios. One key comment on the treasury scenarios was that the prevalence of inverted Yield curves in the scenarios was much higher than would be expected considering relevant history. The parameterization of the treasury model was adjusted to correct for this issue, and a new set of scenarios was produced using this calibration. The specifics of the revised parameterization are explained in the “Outline of Revised Baseline Calibration” file, a “Treasury Parameters – Revised Baseline” excel document, and a series of fan charts. This set of scenarios will be referred to as the “Revised Baseline” and are included on the ESG landing page.

Exposted Items:
- Outline of Revised Baseline Calibration
- GEMS Output for Dec 2019 - Revised Baseline Calibration
- Treasury Parameters – Revised Baseline
- Fan Charts - Revised Parameters
- Average Yield Summary from Basic Data Set – Revised Baseline

**LATF ESG Exposure 2.24.21 for Alternative Calibrations – exposed for comments through 3.22.2021**

(Note: Fan charts shown for this exposure display the Revised Baseline Scenarios as of 2019 Q4 as shaded blue percentiles compared to the Alternative Scenarios described in each file name)

To help regulators and interested parties understand the impact to the scenarios of changing parameters, key targets in the treasury model were altered from their values in the “Revised Baseline” and statistics and graphs were developed from the resulting scenarios. Individual targets for the mean reversion level, mean reversion speed, volatility, and shift parameters were tested. Additionally, a set of scenarios that altered the volatility and shift parameters together was also produced. Finally, the initial conditions in the “Revised Baseline” were updated from 12/31/2019 to 12/31/2020 to illustrate the impact on the scenarios. Details on the altered calibrations described above are described in “Outline of Alternative Calibrations”, Treasury Parameters excel spreadsheets, and fan charts.

Exposed Items:
- Outline of Alternative Calibrations
- Treasury Parameters - Higher MRP
- Fan Charts - Higher MRP
Purpose of the Alternative Treasury Calibrations

The materials described above are being exposed in order to:

- Educate regulators and interested parties on how changing various targets impacts the parameters and corresponding scenarios produced by the ESG, and to
- Generate comments on the desired calibration or calibrations to be utilized in industry field testing.

Supplemental Materials to Prior ESG Exposures

The items listed below are supplemental to previously exposed materials.

LATF ESG Exposure 1.21.21 for ESG Scenario Statistics and Reports – exposed for comments through 3.22.2021

The 1/21/21 ESG Scenario Statistics and Reports exposure detailed reports and statistics that are planned to be delivered with the production scenario files. The files below have been added to give examples of the simulation summary report, the subset reports, and the average Yield summary reports. These reports are based off of the calibration exposed 12/18/2020.

Supplemental Materials:
1000 Path Subset Summary from Basic Data Set exposed 12.18.20
500 Path Subset Summary from Basic Data Set exposed 12.18.20
200 Path Subset Summary from Basic Data Set exposed 12.18.20
50 Path Subset Summary from Basic Data Set exposed 12.18.20
Average Yield Summary from Basic Data Set exposed 12.18.20
Simulation Summary from Basic Data Set exposed 12.18.20
LATF ESG Exposure 1.21.21 for Scenario Picker Tool – exposed for comments through 3.22.2021

The 1/21/21 ESG Scenario Picker Tool exposure detailed a methodology to produce representative subsets from the full set of 10,000 scenarios. The files listed below are the scenario subset files and are based off of the calibration exposed 12/18/2020. Additionally, the “Significance Values – Data” file illustrates how the chosen methodology was used to produce scenario subsets.

Supplemental Materials:
1000 Path Subset from Basic Data Set exposed 12.18.20.
500 Path Subset from Basic Data Set exposed 12.18.20
200 Path Subset from Basic Data Set exposed 12.18.20
50 Path Subset from Basic Data Set exposed 12.18.20
Significance Values – Data

LATF ESG Exposure 1.21.21 for SERT Scenarios – exposed for comments through 3.22.2021

The 1/21/21 Stochastic Exclusion Ratio Test (SERT) exposure described the proposed methodology to produce the VM-20 SERT scenarios using the new ESG. The SERT scenarios produced using the proposed methodology have been added to the website.

Supplemental Materials:
SERT Scenarios from Basic Data Set exposed 12.18.20

Directions on how to access the ESG landing page on Conning’s website

The ESG landing page on Conning’s website, containing all the documents described above, is accessed by navigating to the “Economic Scenarios” section of the NAIC’s PBR website. See below for more details.

Principle-Based Reserving (PBR) Section on the NAIC’s Website

Link: https://content.naic.org/pbr_data.htm

Navigation path: NAIC Home Page → Industry → click in the box for Principle-Based Reserving (PBR) → scroll down to the Economic Scenarios section

ECONOMIC SCENARIOS

Clicking on the link labeled “Economic Scenarios, Tools, Training Materials, and Documentation” will take you to the ESG landing page on Conning’s website. Related files, including files for the ESG Exposures, can be found on the landing page.
The Life Actuarial (A) Task Force met Feb. 11, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Judith L. French, Vice Chair, represented by Jason Wade (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li and Steve Ostlund (AL); Ricardo Lara represented by Ben Bock and Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); Scott A. White represented by Craig Chupp (VA); and James A. Dodrill represented by Tim Sigman (WV). Also attending was: Steve Boston (PA).

1. **Adopted Amendment Proposal 2020-11**

Mr. Robinson discussed his comments (Attachment Four-A) on amendment proposal 2020-11, which recommends revisions to the life principle-based reserving (PBR) exemption to modify the treatment of policies resulting from conversions. Ms. Hemphill said three editorial changes to the amendment proposal were made to reflect some of Mr. Robinson’s comments. The first change revises the language in the third paragraph of Subsection 1.D.1 from “company fails to meet either condition …” to “company does not meet either condition …”. The second and third changes revise Subsection 1.D.2 by respectively placing the words “that would otherwise be” in front of “subject to VM-20” and by deleting the phrase “that are being valued.”

Mr. Leung made a motion, seconded by Ms. Ahrens, to adopt amendment proposal 2020-11 (Attachment Four-B), including the editorial changes proposed by Ms. Hemphill. The motion passed unanimously.

2. **Discussed Amendment Proposal 2019-33**

Mr. Bock said the California Department of Insurance (DOI) comments (Attachment Four-C) on amendment proposal 2019-33 (Attachment Four-D) are largely editorial but specifically mention that the Subsection 1.B and Subsection 1.C references to Subsection 1.F should be revised to clarify whether they refer to Subsection 1.F.1 or Subsection 1.F.2. He said the proposal should also clarify whether retroactivity is permitted and for what years the premium for group business subject to individual underwriting will be included in the premium considered in the determination of eligibility for the PBR exemption. Mary Bahna-Nolan (American Academy of Actuaries—Academy) agreed to make the clarifications to the proposal based on the comments. Ms. Hemphill said the intent is to include all premiums for group business subject to individual underwriting regardless of the issue year. Ms. Allison said amendment proposal 2020-11 may also need clarification on that point.

Mr. Boston said his comment letter (Attachment Four-E) suggests the need for clarification of the transition language in Subsection 1.F.1. Ms. Bahna-Nolan said the intent was to have the language apply only to group life certificates, not to group master contracts. She said the Academy will review the language.

Mr. Robinson said the primary purpose of his comments (Attachment Four-F) is to redraft some of the language. He said his primary suggestion is to bring the footnote into the body of the text. Ms. Bahna-Nolan said the Academy agrees with the comments and will revise its proposal accordingly. Reggie Mazyck (NAIC) said that making a change to the annual statement blank to move the premium for group business subject to individual underwriting from the group column to the individual life column would alleviate the need for referencing group premiums in the footnote.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

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

Rachel Hemphill, TDI – Allows exemption of policies from prior issue years when there is a change in the Life PBR Exemption requirements.

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


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

Valuation Manual Section II, Subsection 1.D

D. Life PBR Exemption

1. A company meeting the at least one of the conditions in D.2 below may file a statement of exemption for ordinary life insurance policies, except for policies in D.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. If a company has no business issued directly or assumed during the current calendar year that would otherwise be subject to VM-20, a statement of exemption is not required. For a filed statement of exemption, the statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that at least one of the two conditions in D.2 was met based on premiums from the prior calendar year annual statement and the statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to Sept. 1 and require the company to follow the requirements of VM-20 for the ordinary life policies covered by the statement.

If a filed statement of exemption is not rejected by the domiciliary commissioner, the filing of subsequent statements of exemption is not required as long as the company continues to qualify for the exemption; rather, ongoing statements of exemption for each new calendar year will be deemed to not be rejected, unless: 1) the company fails to meet either condition in D.2 below, 2) the policies contain those in D.3 below, or 3) the domiciliary commissioner contacts the company prior to Sept. 1 and notifies them that the statement of exemption is rejected. If any of these three events occur, then the statement of exemption for the current calendar year is rejected and a new statement of exemption must be filed and not rejected in order for the company to exempt additional policies. In the case of an ongoing statement of exemption, rather than include a statement of exemption with the NAIC filing for the second quarter of that year, the company should enter “SEE
EXPLANATION™ in response to the Life PBR Exemption supplemental interrogatory and provide as an explanation that the company is utilizing an ongoing statement of exemption.

2. Conditions for Exemption:
   a. The company has less than $300 million of ordinary life premiums1, and if the company is a member of an NAIC group of life insurers, the group has combined ordinary life premiums3 of less than $600 million; or
   b. The only new policies subject to VM-20 being issued or assumed by the company are due to election of policy benefits or features from existing policies that were not being valued under VM-A and VM-C and the company was exempted from, or otherwise not subject to, the requirements of VM-20 in the prior year.

3. Policies Excluded from the Life PBR Exemption:
   a. Universal life with secondary guarantee (ULSG) policies with a secondary guarantee that does not meet the VM-01, Definitions for Terms in Requirements, definition of a “non-material secondary guarantee.”

4. Each exemption, or lack of an exemption, outlined in D.1 – D.3 above applies only to policies issued or assumed in the current year, and it applies to all future valuation dates for those policies. However, if policies did not qualify for the Life PBR Exemption during the year of issue but would have qualified for the Life PBR Exemption if the current Valuation Manual requirements had been in effect during the year of issue, then the domiciliary commissioner may allow an exemption for such policies if such policies qualify for the exemption. The minimum reserve requirements for the ordinary life policies subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

Valuation Manual Section II, Subsection 1.D - Footnote

1 Premiums are measured as total (first year, single, and renewal) direct plus total (first year, single, and renewal) reinsurance assumed from an unaffiliated company from the ordinary life line of business reported in the prior calendar year life/health annual financial statement, Exhibit 1, Part 1, Column 3, “Ordinary Life Insurance” excluding premiums for guaranteed issue policies and preneed life contracts and excluding amounts that represent the transfer of reserves in force as of the effective date of a reinsurance assumed transaction and are reported in Exhibit 1 Part 1, Column 3 as ordinary life insurance premium. Preneed is as defined in VM-01.

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

Addresses the exemption of policies issued in 2020 and 2021 (such as conversions) that may be exempted under the 2022 Valuation Manual requirements but did not qualify under the 2020 or 2021 Valuation Manual requirements.

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

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

Rachel Hemphill, TDI – Allows exemption of policies from prior issue years when there is a change in the Life PBR Exemption requirements.

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Valuation Manual Section II, Subsection 1.D

D. Life PBR Exemption

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The domiciliary commissioner may reject such statement prior to Sept. 1 and require the company to follow the requirements of VM-20 for the ordinary life policies covered by the statement.

If a filed statement of exemption is not rejected by the domiciliary commissioner, the filing of subsequent statements of exemption is not required as long as the company continues to qualify for the exemption; rather, ongoing statements of exemption for each new calendar year will be deemed to not be rejected, unless: 1) the company does not meet either condition in D.2 below, 2) the policies contain those in D.3 below, or 3) the domiciliary commissioner contacts the company prior to Sept. 1 and notifies them that the statement of exemption is rejected. If any of these three events occur, then the statement of exemption for the current calendar year is rejected and a new statement of exemption must be filed and not rejected in order for the company to exempt additional policies. In the case of an ongoing statement of exemption, rather than include a statement of exemption with the NAIC filing for the second quarter of that year, the company should enter “SEE
EXPLANATION™ in response to the Life PBR Exemption supplemental interrogatory and provide as an explanation that the company is utilizing an ongoing statement of exemption.

2. Conditions for Exemption:
   a. The company has less than $300 million of ordinary life premiums1, and if the company is a member of an NAIC group of life insurers, the group has combined ordinary life premiums1 of less than $600 million; or
   b. The only new policies that would otherwise be subject to VM-20 being issued or assumed by the company are due to election of policy benefits or features from existing policies valued under VM-A and VM-C and the company was exempted from, or otherwise not subject to, the requirements of VM-20 in the prior year.

3. Policies Excluded from the Life PBR Exemption:
   a. Universal life with secondary guarantee (ULSG) policies with a secondary guarantee that does not meet the VM-01, Definitions for Terms in Requirements, definition of a “non-material secondary guarantee.”

4. Each exemption, or lack of an exemption, outlined in D.1 – D.3 above applies only to policies issued or assumed in the current year, and it applies to all future valuation dates for those policies. However, if policies did not qualify for the Life PBR Exemption during the year of issue but would have qualified for the Life PBR Exemption if the current Valuation Manual requirements had been in effect during the year of issue, then the domiciliary commissioner may allow an exemption for such policies. The minimum reserve requirements for the ordinary life policies subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

Valuation Manual Section II, Subsection 1.D - Footnote

1 Premiums are measured as total (first year, single, and renewal) direct plus total (first year, single, and renewal) reinsurance assumed from an unaffiliated company from the ordinary life line of business reported in the prior calendar year life/health annual financial statement, Exhibit 1, Part 1, Column 3, “Ordinary Life Insurance” excluding premiums for guaranteed issue policies and preneed life contracts and excluding amounts that represent the transfer of reserves in force as of the effective date of a reinsurance assumed transaction and are reported in Exhibit 1 Part 1, Column 3 as ordinary life insurance premium. Preneed is as defined in VM-01.

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

Addresses the exemption of policies issued in 2020 and 2021 (such as conversions) that may be exempted under the 2022 Valuation Manual requirements but did not qualify under the 2020 or 2021 Valuation Manual requirements.
TO: Mr. Mike Boerner  
Chair, Life Actuarial Task Force  

SUBJECT: APF 2019-33  

DATE: August 18, 2020. December 7, 2020

California has a number of comments, largely editorial in nature, on APF 2019-33. These are as follows:

1. In multiple places, newly proposed language states “... subject to an individual risk selection process and meeting all the conditions in VM-20 Section 1.B”. We think it is redundant to state the first condition (“subject to an individual risk selection process”) since it is listed as a requirement in VM-20 Section 1.B, so we suggest deleting that first part.

2. In item 1.B of Section II, line 3, there is a section reference error. The words “paragraph D” should be changed to “subsection 1.G”. (The use of “subsection” in place of “paragraph” will bring about consistency with other verbiage on this same page.)

3. In subsection 1.B of Section II, we suggest changing “subsection 1.F” to “subsection 1.F.2” for maximum clarity. Similarly, in subsection 1.C of Section II, we suggest changing “subsection 1.F” to “subsection 1.F.1”.

4. In Section II, we suggest switching the ordering of Subsection 1.C and 1.D to improve the flow of the requirements.

5. We think it could be helpful if language were added somewhere to specifically state that there is to be no retroactivity to policies issued before the date of the company’s adoption of this new treatment of individually underwritten group. As worded, the APF is not wrong but there could be some potential for confusion.


7. The last paragraph of Subsection 1.F is a bit confusing, now that two transition periods are being discussed. The phrase “may elect to use the 2017 CSO Tables” is meant to refer only to the 2017-2019 transition period, but it does not quite come across that way. And the phrase “during the three years” may leave the reader wondering which three year period is being discussed.

8. We suggest changing the first 3+ lines of Subsection 1.G.1 to “A company meeting the condition in subsection 1.G.2 below may file a statement of exemption for individual life insurance policies and certificates, except for policies described in subsection 1.G.3. below, ...”

9. Also in subsection 1.G.1 there are some missing words, so we suggest replacing the phrase “that condition subsection G.2 was met” by “that the condition of subsection 1.G.2 was met”.

10. We suggest spelling out the word “September” in the last sentence of subsection 1.G.1.

11. The footnote 1 symbol in the first line of 1.G.2 needs to be turned into a superscript.

12. In the footnote, the parenthetical starts out with “For a statement of exemptions” and we suggest it be “For statements of exemption”.

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13. In VM-20 Section 1.B, we suggest replacing the current lead-in sentence with this: “Individual life certificates under a group life contract shall be subject to the requirements of VM-20 if all of the following are met:” to better conform to the language style of the VM.

14. In VM-20 Section 1.B, it would be more usual to use numbers 1 through 5 rather than Romanettes.

15. In VM-20 1.B.iv (or 1.B.4) we think “similar ... to” would sound better than “similar ... as”.

16. In VM-20 Section 1.B.v (or 1.B.5), we suggest deleting “with an NPR floor” after “principle-based valuation”, since it seems unnecessary.

17. The Guidance Note in VM-20 Section 2.A need not be italicized or bold.

18. The complete cross-out of VM-51 verbiage is a bit confusing. Since we presume there is no intent to delete VM—51, the pages of the APF concerning VM-51 should simply be removed, in our view.

19. Both this APF and the currently pending APF from Rachel Hemphill (# 2020-11) about the Company-wide Exemption propose wording changes in the same area of the Valuation Manual, so at some point someone will need to weave those two sets of wording changes together in a logical way.

Sincerely,

Ben Bock & Elaine Lam
Office of Principle-Based Reserving (OPBR)
Financial Surveillance Branch
California Department of Insurance

CC: Reggie Mazycz
Mary Bahna-Nolan
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

American Academy of Actuaries, Life Reserves Work Group

Addition of language to clarify the definition of individually underwritten life insurance and the applicability of Principle-Based Reserve (PBR) requirements for group insurance contracts with individual risk selection issued under insurance certificates.

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

January 1, 2020 version of the Valuation Manual used.

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

See Appendix

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

Individual insurance certificates issued under a group contract which utilize an individual risk selection process, pricing, premium rate structures and product features are similar to individual life insurance policies. They are currently excluded from VM-20 because they are filed under a group contract, but they should be subject to VM-20 due to this similarity. See Appendix.

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

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Notes: APF 2019-33
Certain contracts issued under a master group contract require individual risk selection in order to qualify for issuance of the group insurance certificate and do not require continued membership in the group in order to maintain coverage. The certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing and risk classification, and are managed in a similar manner as individual ordinary life insurance contracts. These individual certificates should follow the same reserve requirements as other individual life contracts of the same product type. Therefore, a change is needed within the Valuation Manual to bring these individual certificates into scope of VM-20.

Six changes are recommended:

1) Within the Reserve Requirements section (Section II), change the minimum reserve requirements to also apply to group life contracts which, other than the difference between issuing a policy and issuing a group certificate, have the same or mostly similar contract provisions, risk selection process and underwriting as individual ordinary life contracts;

2) Within the Reserve Requirements section (Section II), add a transition period for individual group certificates issued on or before 1/1/2024;

3) Within the Reserve Requirements section (Section II), add language to Subsection 1.D and the corresponding footnote to include premiums from group life contracts which have individual certificates that were issued using individual risk selection processes;

4) Add new paragraph, VM-20 Section 1.B (and reformat to make current paragraph Section 1.A) to clarify group life certificates issued using individual risk selection processes, including a definition and requirements to be met, are subject to the requirements of VM-20;

5) Add guidance note after first sentence in VM-20 Section 2.A.1 that group life certificates that meet the definition for individual risk selection process use the same VM-20 Reserving Categories as defined in Section 2;

6) Draft referral to the NAIC Blanks (E) Working Group, to revise the VM-20 Reserves Supplement, Part 2 to report premiums for total Group Life and Group Life with certificates subjected to an individual risk selection process and which meet all of the conditions as defined in VM-20 Section 1.B separately.
II. Reserve Requirements

This section provides the minimum reserve requirements by type of product, as set forth in the seven subsections below, as follows:

1. Life Insurance Products
2. Annuity Products
3. Deposit-Type Contracts
4. Health Insurance Products
5. Credit Life and Disability Products
6. Riders and Supplemental Benefits
7. Claim Reserves

All reserve requirements provided by this section relate to business issued on or after the operative date of the Valuation Manual. All reserves must be developed in a manner consistent with the requirements and concepts stated in the Overview of Reserve Concepts in Section I of the Valuation Manual.

Guidance Note: The terms “policies” and “contracts” are used interchangeably.

Subsection 1: Life Insurance Products

A. This subsection establishes reserve requirements for all contracts issued on and after the operative date of the Valuation Manual that are classified as life contracts as defined in SSAP No. 50 in the AP&P Manual, with the exception of annuity contracts and credit life contracts. Minimum reserve requirements for annuity contracts and credit life contracts are provided below in subsection 2 and subsection 5, respectively.

B. Minimum reserve requirements for variable and nonvariable individual life contracts—excluding guaranteed issue life contracts, preneed life contracts, industrial life contracts, and policies of companies exempt pursuant to the life PBR exemption in paragraph D below—are provided by VM-20, Requirements for Principle-Based Reserves for Life Products, except for election of the transition period in subsection 1.F below. For this purpose, joint life policies are considered individual life.

C. Minimum reserve requirements for group life contracts with individual certificates which meet all the requirements in VM-20 Section 1.B are provided by VM-20, except for election of the transition period in subsection 1.F below.

D. Minimum reserve requirements of VM-20 are considered principle-based valuation requirements for purposes of the Valuation Manual.

E. Minimum reserve requirements for life contracts not subject to VM-20 are those pursuant to applicable requirements in VM-A and VM-C. For guaranteed issue life contracts issued after Dec. 31, 2018, mortality tables are defined in VM Appendix M – Mortality Tables (VM-M), and the same table shall be used for reserve requirements as is used for minimum nonforfeiture requirements as defined in VM-02, Minimum Nonforfeiture Mortality and Interest.

F. A company may elect to establish minimum reserves pursuant to applicable requirements in VM-A and VM-C for.
1. Business described in subsection 1.C above and issued on or after the operative date of the Valuation Manual and prior to 1/1/2024.

2. Business not described in subsection 1.C otherwise subject to VM-20 requirements and issued during the first three years following the operative date of the Valuation Manual.

A company electing to establish reserves using the requirements of VM-A and VM-C may elect to use the 2017 Commissioners’ Standard Ordinary (CSO) Tables as the mortality standard following the conditions outlined in VM-20 Section 3. If a company during the three years elects to apply VM-20 to a block of such business, then a company must continue to apply the requirements of VM-20 for future issues of this business.

G. Life PBR Exemption

1. A company meeting the condition in subsection G.2 below may file a statement of exemption for ordinary life insurance policies including group life insurance certificates subject to an individual risk selection process and meeting all the conditions in VM-20 Section 1.B, except for policies in subsection G.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. Such a statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that condition subsection G.2 was met based on premiums from the prior calendar year annual statement. The statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to Sept. 1 and require the company to follow the requirements of VM-20 for the ordinary life policies covered by the statement.

2. Condition for Exemption:
   a. The company has less than $300 million of ordinary life premiums1, and if the company is a member of an NAIC group of life insurers, the group has combined ordinary life premiums1 of less than $600 million.

3. Policies Excluded from the Life PBR Exemption:
   a. Universal life with secondary guarantee (ULSG) policies with a secondary guarantee that does not meet the VM-01, Definitions for Terms in Requirements, definition of a “non-material secondary guarantee.”

4. Each exemption, or lack of an exemption, applies only to policies issued or assumed in the current year, and it applies to all future valuation dates for those policies. The minimum reserve requirements for the ordinary life policies subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

Footnote change
Premises are measured as direct plus reinsurance assumed from an unaffiliated company from the ordinary life line of business reported in the prior calendar year life/health annual financial statement, Exhibit 1, Part 1, Column 3, “Ordinary Life Insurance”. Premiums should also include the premiums from group life insurance certificates that were subject to an individual risk selection process and meet all the conditions as defined in VM-20 Section 1.B. For a statement of exemptions filed for calendar year 2022 and beyond, the premiums for these group life certificates were reported in the prior calendar year life/health annual financial statement, VM-20 Reserves Supplement, Part 2, if applicable. Premiums should exclude amounts that represent the transfer of reserves in force as of the effective date of a reinsurance assumed transaction and are reported in Exhibit 1 Part 1, Column 3 as guaranted life insurance premium. Preneed and guaranteed issue life insurance policies are as defined in VM-01.

Commented [A1]: This will need to be added to the PBR Supplement by the NAIC Blanks (E) Working Group.
Section 1: Purpose

A. These requirements establish the minimum reserve valuation standard for individual life insurance policies issued on or after the operative date of the Valuation Manual and subject to a principle-based valuation with an NPR floor under Model #820. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for policies of individual life insurance.

B. If all of the following requirements are met, individual life certificates under a group contract are included in the requirements of VM-20.

(i) An individual risk selection process, defined below, is used to obtain group life insurance coverage;

(ii) The individual certificates utilize premiums or cost of insurance schedules and charges based on the individual applicant’s issue age, duration from underwriting, coverage amount and risk classification and there is a stated or implied schedule of maximum gross premiums or net cash surrender value required in order to continue coverage in force for a period in excess of one year;

(iii) The group master contract is designed, priced, solicited, and managed similar to individual ordinary life insurance policies rather than specific to the group as a whole;

(iv) The individual certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification as individual ordinary life insurance contracts.

The group master contract and individual certificates are issued on or after the operative date of the Valuation Manual and subject to a principle-based valuation with an NPR floor under Model #820.

An individual risk selection process is based on characteristics of the insured(s) beyond sex, gender, age, tobacco usage, and membership in a particular group. This may include, but is not limited to, completion of an application (beyond acknowledgement of membership to the group, sex, gender and age), questionnaire(s), on-line health history or tele-interview to obtain non-medical and medical or health history information, prescription history information, avocations, usage of tobacco, family history, or submission of fluids such as blood, Home Office Specimens (HOS), or oral fluid. The resulting risk classification is determined based on the characteristics of the individual insured(s) rather than the group, if any, of which it is a member (e.g., employer, affinity, etc.). The individual certificate holder is charged a premium rate based solely on the individual risk selection process and not on membership in a specific group.
Guidance Note: The use of evidence of insurability does not by itself constitute an individual risk selection process. Use of information obtained from a census or question(s) regarding gender, occupation, age, income and/or tobacco usage solely for purposes of determining a rate classification does not by itself qualify a group as having used an individual risk selection process. Group insurance where the underwriting is based on the characteristics of the group and census data but where some individuals are subjected to individual risk selection as a result of compensation level, age, an existing medical condition or impairment, late entry into the group, failure of the group to meet minimum participation requirements or voluntary buy-up of increased coverage does not meet the definition of an individual risk selection process.
VM Change 5 - VM-20: Requirements for Principle-Based Reserves for Life Products

Section 2: Minimum Reserve

A. All policies subject to these requirements shall be included in one of the VM-20 Reserving Categories, as specified in Section 2.A.1, Section 2.A.2 and Section 2.A.3 below.

Guidance Note: Since Group Insurance subject to an individual risk selection process and meeting all the requirements, as defined by Section 1.B is subject to VM-20 requirements, Section 2.A shall apply meaning that any such contracts will be included in one of the VM-20 Reserving Categories defined by Section 2.A.1, Section 2.A.2, and 2.A.3. All requirements in VM-31 which apply to a VM-20 Reserving Category shall apply to any group insurance subject to Individual Underwriting Selection that has been included in that VM-20 Reserving Category.

The company may elect to exclude one or more groups of policies from the stochastic reserve calculation and/or the deterministic reserve calculation. When excluding a group of policies from a reserve calculation, the company must document that the applicable exclusion test defined in Section 6 is passed for that group of policies. The minimum reserve for each VM-20 Reserving Category is defined by Section 2.A.1, Section 2.A.2 and Section 2.A.3, and the total minimum reserve equals the sum of the Section 2.A.1, Section 2.A.2 and Section 2.A.3 results below, defined as:
VM Change 6 – VM-20 Reserves Supplement, Part 2: Life PBR Exemption

Refer to NAIC Blanks (E) Working Group, request for modification to the supplemental report for the Life PBR Exemption, to show the premiums for the group life that utilized an individual risk selection process and meets all of the requirements in VM-20 Section 1.B. as these premiums are currently grouped together with other Group Insurance in Exhibit 1. As there are other instances where the ordinary life premiums are not included in the determination of the Life PBR Exemption (e.g., for guaranteed issue policies), it may be useful to request addition of the breakdown of premiums used to determine the exemption:

Possible insertion between questions 1 and 2 for disclosure of premiums used in the determination of eligibility for the Life PBR exemption, split by ordinary life and group subject to an individual risk selection process and meeting all of the requirements in VM-20 Section 1.B.

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Deleted: VM Change 6– VM-51: Experience Reporting Formats, Appendix 4: Mortality Data Elements and Format

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Section 2: Statistical Plan for Mortality

A. Type of Experience Collected Under This Statistical Plan

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

B. Scope of Business Collected Under This Statistical Plan

The data for this statistical plan is the individual ordinary life line of business. Such business is to include direct written business issued in the U.S., and all values should be prior to any reinsurance ceded. Therefore, reinsurance assumed from a ceding company shall be excluded from data collection to avoid double-counting of experience submitted by an issuer and by its reinsurers; however, assumption reinsurance of an individual ordinary life line of business, where the assuming company is legally responsible for all benefits and claims paid, shall be included within the scope of this statistical plan. The ordinary life line of business does not include separate lines of business, such as SI/GI, worksite, individually solicited group life that does not meet all the requirements as defined in VM-20 Section 1.B, direct response, final expense, pre-need, home service, credit life and COLI/BOLI/charity-owned life insurance (CHOLI).

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

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

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

Page Break

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ITEM 1

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Comment on APF 2019-33

In the exposed draft APF 2019-33, I have question about the intent with regard to the transition period language in Subsection 1: Life Insurance Products F. 1.

Can a company elect to value a certificate using VM-A and VM-C if the group master contract was issued before 1/1/2024 but that individual certificate was issued on or after 1/1/2024? If not, do you believe the transition period language is clear enough regarding that the certificate must also be "issued ... prior to 1/1/2024"?

Thanks for any clarification you can provide.

Stephen Boston
Life Actuary
Pennsylvania Insurance Department
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

American Academy of Actuaries, Life Reserves Work Group

Addition of language to clarify the definition of individually underwritten life insurance and the applicability of Principle-Based Reserve (PBR) requirements for group insurance contracts with individual risk selection issued under insurance certificates.

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

January 1, 2020 version of the Valuation Manual used.

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

See Appendix

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

Individual insurance certificates issued under a group contract which utilize an individual risk selection process, pricing, premium rate structures and product features are similar to individual life insurance policies. They are currently excluded from VM-20 because they are filed under a group contract, but they should be subject to VM-20 due to this similarity. See Appendix.

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Notes: APF 2019-33
Appendix

Issue

Certain contracts issued under a master group contract require individual risk selection in order to qualify for issuance of the group insurance certificate and do not require continued membership in the group in order to maintain coverage. The certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing and risk classification, and are managed in a similar manner as individual ordinary life insurance contracts. These individual certificates should follow the same reserve requirements as other individual life contracts of the same product type. Therefore, a change is needed within the Valuation Manual to bring these individual certificates into scope of VM-20.

Eight changes are recommended:

1) Within the Reserve Requirements section (Section II), change the minimum reserve requirements to also apply to group life contracts which, other than the difference between issuing a policy and issuing a group certificate, have the same or mostly similar contract provisions, risk selection process and underwriting as individual ordinary life contracts;

2) Within the Reserve Requirements section (Section II), add a transition period for individual group certificates issued on or before 1/1/2024;

3) Within the Reserve Requirements section (Section II), add language to Subsection 1.D and the corresponding footnote to include premiums from group life contracts which have individual certificates that were issued using individual risk selection processes;

4) Add new paragraph, VM-20 Section 1.B (and reformat to make current paragraph Section 1.A) to clarify group life certificates issued using individual risk selection processes, including a definition and requirements to be met, are subject to the requirements of VM-20;

5) Add guidance note after first sentence in VM-20 Section 2.A.1 that group life certificates that meet the definition for individual risk selection process use the same VM-20 Reserving Categories as defined in Section 2;

6) Modify VM-51 Section 2.B to no longer exempt individually solicited group life which meet the requirements and definitions under items (1) and (2) above; and

7) Modify VM-51, Appendix 4, Item 17 to no longer exempt individually solicited group life contracts which meet the requirements under items (1) and (2) above.

8) Draft referral to the NAIC Blanks (E) Working Group, to revise the VM-20 Reserves Supplement, Part 2 to report premiums for total Group Life and Group Life with certificates subjected to an individual risk selection process and which meet all of the conditions as defined in VM-20 Section 1.B separately.

Commented [A1]: Is this a required criterion? If so, then it needs to be listed in VM-20 Section 1.B.
VM Changes 1, 2 and 3 – II. Reserve Requirements

II. Reserve Requirements

This section provides the minimum reserve requirements by type of product, as set forth in the seven subsections below, as follows:

1. Life Insurance Products
2. Annuity Products
3. Deposit-Type Contracts
4. Health Insurance Products
5. Credit Life and Disability Products
6. Riders and Supplemental Benefits
7. Claim Reserves

All reserve requirements provided by this section relate to business issued on or after the operative date of the Valuation Manual. All reserves must be developed in a manner consistent with the requirements and concepts stated in the Overview of Reserve Concepts in Section I of the Valuation Manual.

Guidance Note: The terms “policies” and “contracts” are used interchangeably.

Subsection 1: Life Insurance Products

A. This subsection establishes reserve requirements for all contracts issued on and after the operative date of the Valuation Manual that are classified as life contracts as defined in SSAP No. 50 in the AP&P Manual, with the exception of annuity contracts and credit life contracts. Minimum reserve requirements for annuity contracts and credit life contracts are provided below in subsection 2 and subsection 5, respectively.

B. Minimum reserve requirements for variable and nonvariable individual life contracts—excluding guaranteed issue life contracts, preneed life contracts, industrial life contracts, and policies of companies exempt pursuant to the life PBR exemption in paragraph D below—are provided by VM-20, Requirements for Principle-Based Reserves for Life Products, except for election of the transition period in subsection 1.F below. For this purpose, joint life policies are considered individual life.

C. Minimum reserve requirements for group life contracts with individual certificates which meet all the requirements in VM-20 Section 1.B are provided by VM-20, except for election of the transition period in subsection 1.F below.

D. Minimum reserve requirements of VM-20 are considered principle-based valuation requirements for purposes of the Valuation Manual.

E. Minimum reserve requirements for life contracts not subject to VM-20 are those pursuant to applicable requirements in VM-A and VM-C. For guaranteed issue life contracts issued after Dec. 31, 2018, mortality tables are defined in VM Appendix M – Mortality Tables (VM-M), and the same table shall be used for reserve requirements as is used for minimum nonforfeiture requirements as defined in VM-02, Minimum Nonforfeiture Mortality and Interest.

F. A company may elect to establish minimum reserves pursuant to applicable requirements in VM-A and VM-C for.
1. Business described in subsection 1.C above and issued on or after the operative date of the Valuation Manual and prior to 1/1/2024.

2. Business not described subsection 1.C otherwise subject to VM-20 requirements and issued during the first three years following the operative date of the Valuation Manual.

A company electing to establish reserves using the requirements of VM-A and VM-C may elect to use the 2017 Commissioners’ Standard Ordinary (CSO) Tables as the mortality standard following the conditions outlined in VM-20 Section 3. If a company during the three years elects to apply VM-20 to a block of such business, then a company must continue to apply the requirements of VM-20 for future issues of this business.

### G. Life PBR Exemption

1. A company meeting the condition in subsection DG.2 below may file a statement of exemption for ordinary life insurance policies including group life insurance certificates subject to an individual risk selection process and meeting all the conditions in VM-20 Section 1.B, except for policies in subsection DG.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. Such a statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that condition subsection DG.2 was met based on premiums from the prior calendar year annual statement. The statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to Sept. 1 and require the company to follow the requirements of VM-20 for the ordinary life policies covered by the statement.

2. Condition for Exemption:

   The company has less than $300 million of exemption premium, and if the company is a member of an NAIC group of life insurers, the group has combined exemption premium of less than $600 million. Exemption premium is determined as follows:

   (a) The amount reported in the prior calendar year life-health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.1;

   (b) The portion of the amount in the prior calendar year life-health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.2 assumed from unaffiliated companies;

   (c) Amounts included in either (a) or (b) that are associated with guaranteed issue insurance policies and/or preneed life insurance policies;

   (d) Amounts included in either (a) or (b) that represent transfers of reserves in force as of the effective date of a reinsurance assumed transaction;

   (e) Amounts of premium for group life certificates that were subject to an individual risk selection process and meet the conditions defined in VM-20, Section 1.B, and that are not included in either (a) or (b).

Guidance Note:

(i) Definitions of preneed and guaranteed issue insurance policy are in VM-01.

(ii) For a statement of exemption filed for calendar year 2022 and beyond, the amount in (e) was reported in the prior calendar year life health annual statement, VM-20 Reserve Supplement, Part 2, if applicable.

Commented [A2]: Replace “including” with “and”

Commented [A3]: Introduce new term.

Commented [A4]: Replaces footnote.

Commented [A5]: This will need to be added to the PBR Supplement by the NAIC Blanks (E) Working Group. (MB-N)
a. The company has less than $300 million of ordinary life premiums1, and if the company is a member of an NAIC group of life insurers, the group has combined ordinary life premiums1 of less than $600 million.

3. Policies Excluded from the Life PBR Exemption:

a. Universal life with secondary guarantee (ULSG) policies with a secondary guarantee that does not meet the VM-01, Definitions for Terms in Requirements, definition of a “non-material secondary guarantee.”

4. Each exemption, or lack of an exemption, applies only to policies issued or assumed in the current year, and it applies to all future valuation dates for those policies. The minimum reserve requirements for the ordinary life policies subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

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Footnote change

1 Premiums are measured as direct plus reinsurance assumed from an unaffiliated company from the ordinary life line of business reported in the prior calendar year life/health annual financial statement, Exhibit 1, Part 1, Column 3, “Ordinary Life Insurance.” Premiums should also include the premiums from group life insurance certificates that were subject to an individual risk selection process and meet all the conditions as defined in VM-20 Section 1.B, and for a statement of exemptions filed for calendar year 2022 and beyond, the premiums for these group life certificates were reported in the prior calendar year life/health annual financial statement, VM-20 Reserves Supplement, Part 2, if applicable. Premiums should excluding premiums for guaranteed issue policies and preneed life contracts and excluding amounts that represent the transfer of reserves in force as of the effective date of a reinsurance assumed transaction and are reported in Exhibit 1, Part 1, Column 3 as ordinary life insurance premium. Preneed and guaranteed issue life insurance policies are as defined in VM-01.

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VM Change 4 – VM-20: Requirements for Principle-Based Reserves for Life Products

VM-20: Requirements for Principles-Based Reserves for Life Products

Section 1: Purpose

A. These requirements establish the minimum reserve valuation standard for individual life insurance policies issued on or after the operative date of the Valuation Manual and subject to a principle-based valuation with an NPR floor under Model #820. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for policies of individual life insurance.

B. If all of the following requirements are met, individual life certificates under a group contract are included subject to the requirements of VM-20 and these requirements constitute the Commissioners Reserve Valuation Method (CRVM) for such certificates.

[iii] An individual risk selection process, defined below, is used to obtain group life insurance coverage:

An individual risk selection process is one that is based on characteristics of the insured(s) beyond sex, gender, age, tobacco usage, and membership in a particular group. This may include, but is not limited to,
An individual risk selection process is based on characteristics of the insured(s) beyond sex, gender, age, tobacco usage, and membership in a particular group. This may include, but is not limited to, completion of an application (beyond acknowledgement of membership to the group, sex, gender and age), questionnaire(s), on-line health history or tele-interview to obtain non-medical and medical or health history information, prescription history information, avocations, usage of tobacco, family history, or submission of fluids such as blood, Home Office Specimens (HOS), or oral fluid. The resulting risk classification is determined based on the characteristics of the individual insured(s) rather than the group, if any, of which it is a member (e.g., employer, affinity, etc.). The individual certificate holder is charged a premium rate based solely on the individual risk selection process and not on membership in a specific group.

**Guidance Note:** The use of evidence of insurability does not by itself constitute an individual risk selection process. Use of information obtained from a census or question(s) regarding gender, occupation, age, income and/or tobacco usage solely for purposes of determining a rate classification does not by itself qualify a group as having used an individual risk selection process. Group insurance where the underwriting based on the characteristics of the group and census data but where some individuals are subjected to individual risk selection as a result of compensation level, age, an existing medical condition or impairment, late entry into the group, failure of the group to meet minimum participation requirements or voluntary buy-up of increased coverage does not meet the definition of an individual risk selection process.

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**Commented [A11]:** Renumber

**Commented [A12]:** Renumber

**Commented [A13]:** Renumber

**Commented [A14]:** Renumber

**Commented [A15]:** Delete. This results from meeting the criteria; it should not be a criterion.

**Commented [A16]:** Moved to a location which allows reference.
Guidance Note: The use of evidence of insurability does not by itself constitute an individual risk selection process. Use of information obtained from a census or question(s) regarding gender, occupation, age, income and/or tobacco usage solely for purposes of determining a rate classification does not by itself qualify a group as having used an individual risk selection process. Group insurance where the underwriting based on the characteristics of the group and census data but where some individuals are subjected to individual risk selection as a result of compensation level, age, an existing medical condition or impairment, late entry into the group, failure of the group to meet minimum participation requirements or voluntary buy-up of increased coverage does not meet the definition of an individual risk selection process.
Section 2: Minimum Reserve

A. All policies subject to these requirements shall be included in one of the VM-20 Reserving Categories, as specified in Section 2.A.1, Section 2.A.2 and Section 2.A.3 below.

Guidance Note: Since Group Insurance subject to an individual risk selection process and meeting all the requirements, as defined by in Section 1.B is subject to VM-20 requirements, Section 2.A shall apply, meaning that any such contracts will be included in one of the VM-20 Reserving Categories defined by Section 2.A.1, Section 2.A.2, and 2.A.3. All requirements in VM-31 which apply to a VM-20 Reserving Category shall apply to any group insurance subject to individual underwriting risk selection that has been included in that VM-20 Reserving Category.

The company may elect to exclude one or more groups of policies from the stochastic reserve calculation and/or the deterministic reserve calculation. When excluding a group of policies from a reserve calculation, the company must document that the applicable exclusion test defined in Section 6 is passed for that group of policies. The minimum reserve for each VM-20 Reserving Category is defined by Section 2.A.1, Section 2.A.2 and Section 2.A.3, and the total minimum reserve equals the sum of the Section 2.A.1, Section 2.A.2 and Section 2.A.3 results below, defined as:
The Life Actuarial (A) Task Force met Feb. 4, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Tynesia Dorsey, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Ben Bock and Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Seivinghaus represented by Vincent Tsang (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlori Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Linda A. Lacewells represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomas Serbinowski (UT); Scott A. White represented by Craig Chupp (VA); and James A. Dodrill represented by Tim Sigman (WV).

1. **Exposed Amendment Proposal 2020-12**

Ms. Hemphill said amendment proposal 2020-12 (Attachment Five-A) provides *Valuation Manual* edits to make the definition of the term “clearly defined hedging strategy” (CDHS) in VM-21, Requirements for Principle-Based Reserves for Variable Annuities, consistent with the definition used in VM-20, Requirements for Principle-Based Reserves for Life Products. She said the definition is also applicable to the principle-based version of VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, currently in development. She noted that the amendment proposal moves the revised definition from VM-20 to VM-01, Definitions for Terms in Requirements. She said the amendment additionally proposes defining a new term, “seasoned hedging strategy” (SHS), which prevents companies from avoiding CDHS requirements by opting to fail one of the qualifying CDHS criteria. The SHS requirements mandate the modeling of an SHS that would increase the minimum reserve or total asset requirement (TAR). Ms. Hemphill also presented coordinating revisions to *Statement of Statutory Accounting Principles (SSAP) 108—Derivatives Hedging Variable Annuity Guarantees* (Attachment Five-B). The coordinating revisions will be forwarded to the Statutory Accounting Principles (E) Working Group following the Task Force adoption of amendment proposal 2020-12.

Mr. Robinson made a motion, seconded by Mr. Leung, to expose amendment proposal 2020-12 for a 50-day public comment period ending March 26. The motion passed unanimously.

2. **Exposed Amendment Proposal 2020-13**

Ms. Hemphill said amendment proposal 2020-13 (Attachment Five-C) revises the VM-20 starting asset collar parameters to correctly apply the collar to a modeled reserve that is negative.

Mr. Weber made a motion, seconded by Mr. Leung, to expose amendment proposal 2020-13 for a 21-day public comment period ending February 26. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

**Identification:**
Rachel Hemphill and Karen Jiang, Texas Department of Insurance

**Title of the Issue:**
Create consistency between CDHS determination in VM-20 and VM-21. Revise hedge modeling to only require CDHS if modeling future hedging reduces the reserves under VM-20 or TAR under VM-21.

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


January 1, 2021 NAIC Valuation Manual

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

See attached.

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

We propose having consistent requirements for a CDHS in VM-20 and VM-21, as well as any future work on VM-22, and consolidating these requirements in the VM-01 definition of a CDHS. This involves adding two criteria to VM-21’s definition of CDHS that currently exist for VM-20:

- Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
- The circumstances under which hedging strategy will not be effective in hedging the risks.

These criteria are both reasonable and apply in principle to VM-21, and to any future work on VM-22, as well as VM-20.

Further, we propose revising the requirement for hedging to be a CDHS in order for future hedging to be modeled under VM-20, VM-21, and LR027’s C-3 RBC Amount calculation to only apply when modeling such hedging reduces the life reserve level or variable annuity Total Asset Requirement (TAR) level.

The current regulatory requirements for hedging to be a CDHS in order for future hedging to be modeled under VM-20, modeled under VM-21, modeled for the C-3 RBC Amount calculation for variable annuities,
and to be eligible for SSAP 108 treatment are all logical requirements when one considers whether hedging should be allowed to reduce the life reserve level or variable annuity TAR level, or whether any mismatch between movements in hedge assets and movements in the corresponding reserve levels should be allowed to be amortized over time.

However, this same requirement has led to a situation of there being unintended optionality in whether a hedging strategy that is like a CDHS is modeled or is not modeled, since a company may choose to satisfy or not satisfy certain of the criteria. This has been especially relevant for cases where modeling a company’s hedging strategy would increase reserves or variable annuity TAR.

As noted in the current guidance note in VM-20 Section 7.K.1 in the 2021 Valuation Manual:

“The prohibition in these modeled reserve requirements against projecting future hedging transactions other than those associated with a clearly defined hedging strategy is intended to address initial concerns expressed by various parties that reserves could be unduly reduced by reflection of programs whose future execution and performance may have greater uncertainty. The prohibition appears, however, to be in conflict with Principle 2 listed in VM-21. Companies may actually execute and reflect in their risk assessment and evaluation processes hedging strategies similar in many ways to clearly defined hedging strategies but lack sufficient clarity in one or more of the qualification criteria. By excluding the associated derivative instruments, the investment strategy that is modeled may also not reflect the investment strategy the company actually uses. Further, because the future hedging transactions may be a net cost to the company in some scenarios and a net benefit in other scenarios, the exclusion of such transactions can result in a modeled reserve that is either lower or higher than it would have been if the transactions were not excluded. The direction of such impact on the reserves could also change from period to period as the actual and projected paths of economic conditions change. A more graded approach to recognition of non-qualifying hedging strategies may be more theoretically consistent with Principle 2. It is recommended that as greater experience is gained by actuaries and state insurance regulators with the principle-based approach and as industry hedging programs mature, the various requirements of this section be reviewed.”

We propose to continue addressing the regulatory concern that reserves could be unduly reduced by reflection of programs whose future execution and performance may have greater uncertainty, by continuing to only allowing hedging strategies that qualify as a CDHS to reduce life reserves and variable annuity TAR. However, we propose that the treatment of CDHS be made more principles-based and less subject to manipulation. To accomplish this, the proposal requires that any hedging strategy that is a part of the investment strategy supporting the policies and is normally modeled as part of the company’s risk assessment and evaluation processes be modeled as if it were a CDHS if doing so results in an increase in life reserves or variable annuity TAR.

That is, CDHS becomes a requirement solely for hedging strategies that reduce life reserves or variable annuity TAR, and so becomes a more clear regulatory guardrail requiring that hedging strategies that reduce life reserves or variable annuity TAR must be clearly defined.

We continue to need the concept of a CDHS. A CDHS simply formally documents items that a company should be able to document for a robust, well-defined hedging strategy. It requires that the following be identified:

a. The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
b. The hedge objectives.
c. The risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
d. The financial instruments used to hedge the risks.
e. The hedge trading rules, including the permitted tolerances from hedging objectives.
f. The metrics for measuring hedging effectiveness.
g. The criteria used to measure hedging effectiveness.
h. The frequency of measuring hedging effectiveness.
i. The conditions under which hedging will not take place.
j. The person or persons responsible for implementing the hedging strategy.
k. Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
l. The circumstances under which hedging strategy will not be effective in hedging the risks.

While the last two criteria have historically applied for life but not variable annuities, these are all reasonable documentation items that for a robust, well-defined hedging strategy regardless of whether the product is life or variable annuity.

The concept of a CDHS is used for accounting in SSAP 108. SSAP 108 allows companies to set up a deferred asset or liability to amortize the mismatch between changes in the value of the liability and changes in the value of the hedging instruments attributable to the hedged risk underlying a highly effective CDHS modeled for VM-21. Allowing this treatment encourages companies to reduce risk through robust, well-defined and highly effective hedging. Without having the hedging strategy be well-defined, regulators could not rely on past effectiveness being indicative of future effectiveness, and so could not offer companies the benefit of SSAP 108 treatment. Once we recognize the need for a concept of a well-defined hedging strategy, the only question is what criteria would need to be met to be considered well-defined – that is, what criteria should be required to be considered a CDHS. This is a distinct question from whether the concept of a CDHS is needed. We have not heard critiques of individual criteria in the CDHS definition, but consideration of the criteria is appropriate as we go forward to make the definitions in VM-20 and VM-21 consistent. Similarly, in reserve and capital calculations, we rely on the concept of historical effectiveness to determine an error factor. If modeling hedging reduces the reserve or capital amount, the error factor determines the magnitude to which this is reflected. However, this use of the historical effectiveness relies on the hedging strategy being well-documented and comparable between historical hedging and planned future hedging. So, again, a need for hedging strategies to be well-defined presents itself – a CDHS concept is needed.

Finally, edits to VM-31 are needed to reflect these updates and bring VM-20 and VM-21 reporting requirements more in line with one another where appropriate.

**Note on Coordination with RBC and APPM:** We have reviewed, and with these edits there are no corresponding edits necessary for LR027 for RBC but corresponding edits are necessary for SSAP 108. A referral to SAPWG is to be concurrently considered with this APF.

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

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### Dates: Received

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### Notes:

APF 2020-12

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W:\National Meetings\2010\TF\LHA\Attachment Five-A

Life Actuarial (A) Task Force

4/8/21
VM-01

1. The term “clearly defined hedging strategy” (CDHS) means a strategy undertaken by a company to manage risks through the future purchase or sale of hedging instruments and the opening and closing of hedging positions. A CDHS must identify:
   a. The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
   b. The hedge objectives.
   c. The risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
   d. The financial instruments used to hedge the risks.
   e. The hedge trading rules, including the permitted tolerances from hedging objectives.
   f. The metrics for measuring hedging effectiveness.
   g. The criteria used to measure hedging effectiveness.
   h. The frequency of measuring hedging effectiveness.
   i. The conditions under which hedging will not take place.
   j. The person or persons responsible for implementing the hedging strategy.
   k. Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
   l. The circumstances under which hedging strategy will not be effective in hedging the risks.

   The hedge strategy may be dynamic, static or a combination thereof. A strategy involving the offsetting of the risks associated with products falling under the scope of different requirements within the Valuation Manual (e.g., VM-20, VM-21, or VM-22) does not qualify as CDHS. A CDHS must meet all of the principles outlined in VM-21 Section 1.B (the most relevant of which may be Principle 5).

Guidance Note: For purposes of the above criteria, “effectiveness” need not be measured in a manner as defined in SSAP No. 86—Derivatives in the AP&P Manual.

2. The term “Seasoned Hedging Strategy” (SHS) means a hedging strategy that is part of the company’s investment strategy and is normally modeled as part of the company’s risk assessment and evaluation process. A SHS may or may not be a CDHS.

   The hedge strategy may be dynamic, static or a combination thereof. A strategy involving the offsetting of the risks associated with products falling under the scope of different requirements within the Valuation Manual (e.g., VM-20, VM-21, or VM-22) does not qualify as SHS. A SHS must meet all of the principles outlined in VM-21 Section 1.B (the most relevant of which may be Principle 5).
VM-20 Section 6.A.1.b

A company may not exclude a group of policies for which there is one or more CDHS or one or more SHS required to be modeled pursuant to Section 7.K.4 from stochastic reserve requirements, except in the case where all CDHS and all SHS required to be modeled pursuant to Section 7.K.4 are solely associated with product features that are determined to not be material under Section 7.B.1 due to low utilization.

VM-20 Section 7.E.1.g

Notwithstanding the above requirements, the modeled reserve shall be the higher of that produced by the model investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the model investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a CDHS (in compliance with the definition of CDHS in VM-01) or a SHS that is required to be modeled pursuant to Section 7.K.4 are not affected by this requirement.

VM-20 Section 7.K

K. Modeling of Derivative Programs

1. When determining the deterministic reserve and the stochastic reserve, the company shall include in the projections the appropriate costs and benefits of derivative instruments that are currently held by the company in support of the policies subject to these requirements. The company shall also include the appropriate costs and benefits of anticipated future derivative instrument transactions associated with the execution of a CDHS or a SHS that is required to be modeled pursuant to Section 7.K.4, as well as the appropriate costs and benefits of anticipated future derivative instrument transactions associated with non-hedging derivative programs (e.g., replication, income generation) undertaken as part of the investment strategy supporting the policies, provided they are normally modeled as part of the company’s risk assessment and evaluation processes.

2. For each derivative program that is modeled, the company shall reflect the company’s established investment policy and procedures for that program; project expected program performance along each scenario; and recognize all benefits, residual risks and associated frictional costs. The residual risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, etc.). Frictional costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. For CDHS or SHS required to be modeled pursuant to Section 7.K.4, the company may not assume that residual risks and frictional costs have a value of zero, unless the company demonstrates in the PBR Actuarial Report that “zero” is an appropriate expectation.
3. In circumstances where one or more material risk factors related to a derivative program are not fully captured within the cash-flow model used to calculate CTE 70, the company shall reflect such risk factors by increasing the stochastic reserve as described in Section 5.E.

4. If a SHS is not a CDHS but modeling it would result in an increase to the company’s minimum reserve, then the company shall model the SHS as if it were a CDHS when calculating reserves under VM-20.

**VM-20 Section 7.L (Remove entire Section 7.L)**

**Deleted:**

A clearly defined hedging strategy must identify:

- The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
- The hedge objectives.
- The risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
- The financial instruments used to hedge the risks.
- The hedge trading rules, including the permitted tolerances from hedging objectives.
- The metrics for measuring hedging effectiveness.
- The frequency of measuring hedging effectiveness.
- The conditions under which hedging will not take place.
- The person or persons responsible for implementing the hedging strategy.
- Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
- The circumstances under which hedging strategy will not be effective in hedging the risks.
- Hedging strategies involving the offsetting of the risks associated with other products outside of the scope of these requirements is not a clearly defined hedging strategy.

**Guidance Note:** For purposes of the above criteria, “effectiveness” need not be measured in a manner as defined in SSAP No. 86—Derivatives in the AP&P Manual.
VM-21 Section 1.D.2 (Delete entire definition and renumber subsequent sections VM-21 Section 1.D.3 and VM-21 Section 1.D.4)

VM-21 Section 4.A.4

Modeling of Hedges
a. For a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6:
   i. The company shall not consider the cash flows from any future hedge purchases or any rebalancing of existing hedge assets in its modeling.
   ii. Existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets. The hedge assets may then be considered in one of two ways:
      a) Include the asset cash flows from any contractual payments and maturity values in the projection model; or
      b) No hedge positions — in which case the hedge positions held on the valuation date are replaced with cash and/or other general account assets in an amount equal to the aggregate market value of these hedge positions.

Guidance Note: If the hedge positions held on the valuation date are replaced with cash, then as with any other cash, such amounts may then be invested following the company’s investment strategy.

A company may switch from method a) to method b) at any time, but it may only change from b) to a) with the approval of the domiciliary commissioner.

b. For a company with a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6, the detailed requirements for the modeling of hedges are defined in Section 9. The following paragraphs are a high-level summary and do not supersede the detailed requirements.
   i. The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the projections used in the determination of the stochastic reserve.
   ii. The projections shall take into account the appropriate costs and benefits of hedge positions expected to be held in the future through the execution of the CDHS or the SHS that is required to be modeled pursuant to Section 9.A.6. Because models do not always accurately portray the results of hedge programs, the company shall, through back-testing and other means, assess the accuracy of the hedge modeling. The company shall determine a stochastic reserve as the weighted average of two CTE values; first, a CTE70 (“best efforts”) representing the company’s projection of all of the hedge cash flows, including future hedge purchases, and a second CTE70 (“adjusted”) which shall use only hedge assets held by the company on the valuation date and no future hedge purchases. These are discussed in greater detail in Section 9. The stochastic reserve

Deleted: The term “clearly defined hedging strategy” (CDHS) is defined in VM-01. In order to be designated as a CDHS, the strategy must meet the principles outlined in Section 1.B (particularly Principle 5) and shall, at a minimum, identify:
   i. The specific risks being hedged (e.g., delta, rho, vega, etc.).
   ii. The hedge objectives.
   iii. The risks not being hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
   iv. The financial instruments that will be used to hedge the risks.
   v. The hedge trading rules, including the permitted tolerances from hedging objectives.
   vi. The metrics for measuring hedging effectiveness.
   vii. The criteria that will be used to measure hedging effectiveness.
   viii. The frequency of measuring hedging effectiveness.
   ix. The conditions under which hedging will not take place.
   x. The person or persons responsible for implementing the hedging strategy.

Guidance Note: It is important to note that strategies involving the offsetting of the risks associated with VA guarantees with other products outside of the scope of these requirements (e.g., equity-indexed annuities) do not currently qualify as a clearly defined hedging strategy under these requirements.
shall be the weighted average of the two CTE70 values, where the weights reflect the error factor (E) determined following the guidance of Section 9.C.4.

iii. The company is responsible for verifying compliance with CDHS requirements, or SHS requirements if required to be modeled pursuant to Section 9.A.6, and any other requirements in Section 9 for all hedging instruments included in the projections.

iv. The use of products not falling under the scope of these requirements (e.g., equity-indexed annuities) as a hedge shall not be recognized in the determination of accumulated deficiencies.

VM-21 Section 4.D.4.b

Notwithstanding the above requirements, the model investment strategy and any non-prescribed asset spreads shall be adjusted as necessary so that the aggregate reserve is not less than that which would be obtained by substituting an alternative investment strategy in which all fixed income reinvestment assets are public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a CDHS (in compliance with the definition of CDHS in VM-01) or a SHS that is required to be modeled pursuant to Section 9.A.6 are not affected by this requirement.

VM-21 Section 6.B.3.a.ii – Footnote (Footnote at Bottom of Page 21-22)

Throughout this Section 6, references to CTE70 (adjusted) shall also mean the Stochastic Reserve for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6 as discussed in Section 4.A.4.a.

VM-21 Section 6.B.3.b.ii

Calculate the Prescribed Projections Amount as the CTE70 (adjusted) using the same method as that outlined in Section 9.C (which is the same as the stochastic reserves following Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6) but substituting the assumptions prescribed by Section 6.C. The calculation of this Prescribed Projections Amount also requires that the scenario reserve for any given scenario be equal to or in excess of the cash surrender value in aggregate on the valuation date for the group of contracts modeled in the projection.

VM-21 Section 6.B.5

Cash flows associated with hedging shall be projected in the same manner as that used in the calculation of the CTE70 (adjusted) as discussed in Section 9.C or Section 4.A.4.a for a company without a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6.
VM-21 Section 9

Section 9: Modeling of Hedges under a CDHS

A. Initial Considerations

1. Subject to Section 9.C.2, the appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the calculation of the stochastic reserve, determined in accordance with Section 3.D and Section 4.D.

2. If the company is following a CDHS, in accordance with an investment policy adopted by the board of directors, or a committee of board members, the company shall take into account the costs and benefits of hedge positions expected to be held by the company in the future along each scenario based on the execution of the hedging strategy, and it is eligible to reduce the amount of the stochastic reserve using projections otherwise calculated. The investment policy must clearly articulate the company’s hedging objectives, including the metrics that drive rebalancing/trading. This specification could include maximum tolerable values for investment losses, earnings, volatility, exposure, etc. in either absolute or relative terms over one or more investment horizons vis-à-vis the chance of occurrence. Company management is responsible for developing, documenting, executing and evaluating the investment strategy, including the hedging strategy, used to implement the investment policy.

3. For this purpose, the investment assets refer to all the assets, including derivatives supporting covered products and guarantees. This also is referred to as the investment portfolio. The investment strategy is the set of all asset holdings at all points in time in all scenarios. The hedging portfolio, which also is referred to as the hedging assets, is a subset of the investment assets. The hedging strategy is the hedging asset holdings at all points in time in all scenarios. There is no attempt to distinguish what is the hedging portfolio and what is the investment portfolio in this section. Nor is the distinction between investment strategy and hedging strategy formally made here. Where necessary to give effect to the intent of this section, the requirements applicable to the hedging portfolio or the hedging strategy are to apply to the overall investment portfolio and investment strategy.

4. This particularly applies to restrictions on the reasonableness or acceptability of the models that make up the stochastic cash-flow model used to perform the projections, since these restrictions are inherently restrictions on the joint modeling of the hedging and non-hedging portfolio. To give effect to these requirements, they must apply to the overall investment strategy and investment portfolio.

5. Before either a new or revised hedging strategy can be used to reduce the amount of the stochastic reserve otherwise calculated, the hedging strategy should be in place (i.e., effectively implemented by the company) for at least three months. The company may meet the time requirement by having evaluated the effective implementation of the hedging strategy for at least three months without actually having executed the trades indicated by the hedging strategy (e.g., mock testing or by having effectively implemented the strategy with similar annuity products for at least three months).

6. If a SHS is not a CDHS but modeling it as if it were a CDHS would result in an increase in the company’s TAR, then the company shall model the SHS as if it were a CDHS when calculating reserves under AG43 and/or VM-21 and when calculating the C-3 RBC Amount under LR027. The company shall not treat the SHS as a CDHS for purposes of SSAP 108.
B. Modeling Approaches

1. The analysis of the impact of the hedging strategy on cash flows is typically performed using either one of two types of methods as described below. Although a hedging strategy normally would be expected to reduce risk provisions, the nature of the hedging strategy and the costs to implement the strategy may result in an increase in the amount of the stochastic reserve otherwise calculated.

2. The fundamental characteristic of the first type of method, referred to as the “explicit method,” is that hedging positions and their resulting cash flows are included in the stochastic cash-flow model used to determine the scenario reserve, as discussed in Section 3.D, for each scenario.

3. The fundamental characteristic of the second type of method, referred to as the “implicit method,” is that the effectiveness of the current hedging strategy on future cash flows is evaluated, in part or in whole, outside of the stochastic cash-flow model. There are multiple ways that this type of modeling can be implemented. In this case, the reduction to the stochastic reserve otherwise calculated should be commensurate with the degree of effectiveness of the hedging strategy in reducing accumulated deficiencies otherwise calculated.

4. Regardless of the methodology used by the company, the ultimate effect of the current hedging strategy (including currently held hedge positions) on the stochastic reserve needs to recognize all risks, associated costs, imperfections in the hedges and hedging mismatch tolerances associated with the hedging strategy. The risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, annuitization, etc.). Costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. In addition, the reduction to the stochastic reserve attributable to the hedging strategy may need to be limited due to the uncertainty associated with the company’s ability to implement the hedging strategy in a timely and effective manner. The level of operational uncertainty varies indirectly with the amount of time that the new or revised strategy has been in effect or mock tested.

**Guidance Note:** No hedging strategy is perfect. A given hedging strategy may eliminate or reduce some but not all risks, transform some risks into others, introduce new risks, or have other imperfections. For example, a delta-only hedging strategy does not adequately hedge the risks measured by the “Greeks” other than delta. Another example is that financial indices underlying typical hedging instruments typically do not perform exactly like the separate account funds, and hence the use of hedging instruments has the potential for introducing basis risk.

5. A safe harbor approach is permitted for CDHS reflection for those companies whose modeled hedge assets comprise only linear instruments not sensitive to implied volatility. For companies with option-based hedge strategies, electing this approach would require representing the option-based portion of the strategy as a delta-rho two-Greek hedge program. The normally modeled option portfolio would be replaced with a set of linear instruments that have the same first-order Greeks as the original option portfolio.

C. Calculation of Stochastic Reserve (Reported)

1. The company shall calculate CTE70 (best efforts)—the results obtained when the CTE70 is based on incorporating the CDHS (including both currently held and future hedge positions) into the stochastic cash-flow model on a best efforts basis, including all of the factors and assumptions needed to execute the CDHS
(e.g., stochastic implied volatility). The determination of CTE70 (best efforts) may utilize either explicit or implicit modeling techniques.

2. The company shall calculate a CTE70 (adjusted) by recalculating the CTE70 assuming the company has no CDHS, therefore following the requirements of Section 4.A.4.a.

3. Because most models will include at least some approximations or idealistic assumptions, CTE70 (best efforts) may overstate the impact of the hedging strategy. To compensate for potential overstatement of the impact of the hedging strategy, the value for the stochastic reserve is given by:

\[
\text{Stochastic reserve} = \text{CTE70 (best efforts)} + E \times \max[0, \text{CTE70 (adjusted)} - \text{CTE70 (best efforts)}]
\]

4. The company shall specify a value for \( E \) (the “error factor”) in the range from 5% to 100% to reflect the company’s view of the potential error resulting from the level of sophistication of the stochastic cash-flow model and its ability to properly reflect the parameters of the hedging strategy (i.e., the Greeks being covered by the strategy), as well as the associated costs, risks and benefits. The greater the ability of the stochastic model to capture all risks and uncertainties, the lower the value of \( E \). The value of \( E \) may be as low as 5% only if the model used to determine the CTE70 (best efforts) effectively reflects all of the parameters used in the hedging strategy. If certain economic risks are not hedged, yet the model does not generate scenarios that sufficiently capture those risks, \( E \) must be in the higher end of the range, reflecting the greater likelihood of error. Likewise, simplistic hedge cash-flow models shall assume a higher likelihood of error.

5. The company shall conduct a formal back-test, based on an analysis of at least the most recent 12 months, to assess how well the model is able to replicate the hedging strategy in a way that supports the determination of the value used for \( E \).

6. Such a back-test shall involve one of the following analyses:

a. For companies that model hedge cash flows directly (“explicit method”), replace the stochastic scenarios used in calculating the CTE70 (best efforts) with a single scenario that represents the market path that actually manifested over the selected back-testing period and compare the projected hedge asset gains and losses against the actual hedge asset gains and losses – both realized and unrealized – observed over the same time period. For this calculation, the model assumptions may be replaced with parameters that reflect actual experience during the back-testing period. In order to isolate the comparison between the modeled hedge strategy and actual hedge results for this calculation, the projected liabilities should accurately reflect the actual liabilities throughout the back-testing period; therefore, adjustments that facilitate this accuracy (e.g. reflecting actual experience instead of model assumptions, including new business, etc.) are permissible.

To support the choice of a low value of \( E \), the company should ascertain that the projected hedge asset gains and losses are within close range of 100% (e.g., 80–125%) of the actual hedge asset gains and losses. The company may also support the choice of a low value of \( E \) by achieving a high R-squared (e.g., 0.80 or higher) when using a regression analysis technique.

b. For companies that model hedge cash flows implicitly by quantifying the cost and benefit of hedging using the fair value of the hedged item (an “implicit method” or “cost of reinsurance method”), calculate the delta, rho and vega coverage ratios in each month over the selected back-testing period in the following manner:
i. Determine the hedge asset gains and losses—both realized and unrealized—incurred over the month attributable to equity, interest rate, and implied volatility movements.

ii. Determine the change in the fair value of the hedged item over the month attributable to equity, interest rate, and implied volatility movements. The hedged item should be defined in a manner that reflects the proportion of risks hedged (e.g., if a company elects to hedge 50% of a contract’s market risks, it should quantify the fair value of the hedged item as 50% of the fair value of the contract).

iii. Calculate the delta coverage ratio as the ratio between (i) and (ii) attributable to equity movements.

iv. Calculate the rho coverage ratio as the ratio between (i) and (ii) attributable to interest rate movements.

v. Calculate the vega coverage ratio as the ratio between (i) and (ii) attributable to implied volatility movements.

vi. To support the company’s choice of a low value of E, the company should be able to demonstrate that the delta and rho coverage ratios are both within close range of 100% (e.g., 80–125%) consistently across the back-testing period.

vii. In addition, the company should be able to demonstrate that the vega coverage ratio is within close range of 100% in order to use the prevailing implied volatility levels as of the valuation date in quantifying the fair value of the hedged item for the purpose of calculating CTE70 (best efforts). Otherwise, the company shall quantify the fair value of the hedged item for the purpose of calculating CTE70 (best efforts) in a manner consistent with the realized volatility of the scenarios captured in the CTE (best efforts).

c. Companies that do not model hedge cash flows explicitly, but that also do not use the implicit method as outlined in Section 9.C.6.b above, shall conduct the formal back-test in a manner that allows the company to clearly illustrate the appropriateness of the selected method for reflecting the cost and benefit of hedging, as well as the value used for E.

7. A company that does not have 12 months of experience to date shall set E to a value that reflects the amount of experience available, and the degree and nature of any change to the hedge program. For a material change in strategy, with no history, E should be at least 0.50. However, E may be lower than 0.50 if some reliable experience is available and/or if the change in strategy is a refinement rather than a substantial change in strategy.

**Guidance Note:** The following examples are provided as guidance for determining the E factor when there has been a change to the hedge program:

- The error factor should be temporarily large (e.g., ≥ 50%) for substantial changes in hedge methodology (e.g., moving from a fair-value based strategy to a stop-loss strategy) where the company has not been able to provide a meaningful simulation of hedge performance based on the new strategy.
- A temporary moderate increase (e.g., 15–30%) in error factor should be used for substantial modifications to hedge programs or CDHS modeling where meaningful simulation has not been created (e.g., adding second-order hedging, such as gamma or rate convexity).
- No increase in the error factor may be used for incremental modifications to the hedge strategy (e.g., adding death benefits to a program that previously covered only living benefits, or moving from swaps to Treasury Department futures).

D. Additional Considerations for CTE70 (best efforts)
If the company is following a CDHS, the fair value of the portfolio of contracts falling within the scope of these requirements shall be computed and compared to the CTE70 (best efforts) and CTE70 (adjusted). If the CTE70 (best efforts) is below both the fair value and CTE70 (adjusted), the company should be prepared to explain why that result is reasonable.

For the purposes of this analysis, the stochastic reserve and fair value calculations shall be done without requiring the scenario reserve for any given scenario to be equal to or in excess of the cash surrender value in aggregate for the group of contracts modeled in the projection.

E. Specific Considerations and Requirements

1. As part of the process of choosing a methodology and assumptions for estimating the future effectiveness of the current hedging strategy (including currently held hedge positions) for purposes of reducing the stochastic reserve, the company should review actual historical hedging effectiveness. The company shall evaluate the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, the mix of business and other items that are likely to result in materially adverse results. This includes an analysis of model assumptions that, when combined with the reliance on the hedging strategy, are likely to result in adverse results relative to those modeled. The parameters and assumptions shall be adjusted (based on testing contingent on the strategy used and other assumptions) to levels that fully reflect the risk based on historical ranges and foreseeable future ranges of the assumptions and parameters. If this is not possible by parameter adjustment, the model shall be modified to reflect them at either anticipated experience or adverse estimates of the parameters.

2. A discontinuous hedging strategy is a hedging strategy where the relationships between the sensitivities to equity markets and interest rates (commonly referred to as the Greeks) associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets are subject to material discontinuities. This includes, but is not limited to, a hedging strategy where material hedging assets will be obtained when the variable annuity account balances reach a predetermined level in relationship to the guarantees. Any hedging strategy, including a delta hedging strategy, can be a discontinuous hedging strategy if implementation of the strategy permits material discontinuities between the sensitivities to equity markets and interest rates associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets. There may be scenarios that are particularly costly to discontinuous hedging strategies, especially where those result in large discontinuous changes in sensitivities (Greeks) associated with the hedging assets. Where discontinuous hedging strategies contribute materially to a reduction in the stochastic reserve, the company must evaluate the interaction of future trigger definitions and the discontinuous hedging strategy, in addition to the items mentioned in the previous paragraph. This includes an analysis of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.

3. A strategy that has a strong dependence on acquiring hedging assets at specific times that depend on specific values of an index or other market indicators may not be implemented as precisely as planned.

4. The combination of elements of the stochastic cash-flow model—including the initial actual market asset prices, prices for trading at future dates, transaction costs and other assumptions—should be analyzed by the company as to whether the stochastic cash-flow model permits hedging strategies that make money in some scenarios without losing a reasonable amount in some other scenarios. This includes, but is not limited to:
a. Hedging strategies with no initial investment that never lose money in any scenario and in some scenarios make money.
b. Hedging strategies that, with a given amount of initial money, never make less than accumulation at the one-period risk-free rates in any scenario but make more than this in one or more scenarios.

5. If the stochastic cash-flow model allows for such situations, the company should be satisfied that the results do not materially rely directly or indirectly on the use of such strategies. If the results do materially rely directly or indirectly on the use of such strategies, the strategies may not be used to reduce the stochastic reserve otherwise calculated.

6. In addition to the above, the method used to determine prices of financial instruments for trading in scenarios should be compared to actual initial market prices. In addition to comparisons to initial market prices, there should be testing of the pricing models that are used to determine subsequent prices when scenarios involve trading financial instruments. This testing should consider historical relationships. For example, if a method is used where recent volatility in the scenario is one of the determinants of prices for trading in that scenario, then that model should approximate actual historic prices in similar circumstances in history.

**VM-31 Section 3.C.5**

**Assets and Risk Management** – A brief description of the asset portfolio, and the approach used to model risk management strategies, such as hedging, and other derivative programs, including a description of any CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4.

**VM-31 Section 3.D.6.f**

**Risk Management** – Detailed description of model risk management strategies, such as hedging and other derivative programs, specific to the groups of policies covered in this sub-report and not discussed in the Life Summary Section 3.C.5. This should include documentation for any hedging strategy that meets the requirements to be a CDHS. It should also include, for any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4, documentation of any CDHS criteria met, listing of CDHS criteria not met, and documentation of the reserve level with and without the SHS being modeled as if it were a CDHS.


a. **Investment Officer on Investments** – A certification from a duly authorized investment officer that the modeled company investment strategy, including any CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4, is representative of and consistent with the company’s investment policy.
b. **Qualified Actuary on Investments** – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4 was performed in accordance with VM-20 and in compliance with all applicable ASOPs, and the alternative investment strategy as defined in VM-20 Section 7.E.1.g reflects the prescribed mix of assets with the same WAL as the reinvestment assets in the company investment strategy.

Deleted: clearly defined hedging strategies

Deleted: clearly defined hedging strategies

Deleted: clearly defined hedging strategies
VM-31 Section 3.E.5

Assets and Risk Management – A brief description of the general account asset portfolio, and the approach used to model risk management strategies, such as hedging and other derivative programs, including a description of any CDHS or any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, and any material changes to the hedging strategy from the prior year.

VM-31 Section 3.F.8

Hedging and Risk Management – The following information regarding the hedging and risk management assumptions used by the company in performing a principle-based valuation under VM-21:

a. Strategies – Detailed description of risk management strategies, such as hedging and other derivative programs, including any CDHS or any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, specific to the groups of contracts covered in this sub-report.
   i. Descriptions of basis risk, gap risk, price risk and assumption risk.
   ii. Methods and criteria for estimating the a priori effectiveness of the strategy.
   iii. Results of any reviews of actual historical hedging effectiveness.

b. CDHS – Documentation for any hedging strategy that meets the requirements to be a CDHS.

c. Other Modeled Hedging Strategies – Documentation for any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, including documentation of any CDHS criteria met, listing of CDHS criteria not met, and documentation of the TAR level with and without the SHS being modeled as if it were a CDHS.

d. Strategy Changes – Discussion of any changes to the hedging strategy during the past 12 months, including identification of the change, reasons for the change, and the implementation date of the change.

e. Hedge Modeling – Description of how the hedge strategy was incorporated into modeling, including:
   i. Differences in timing between model and actual strategy implementation.
   ii. For a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, disclosure of the method used to consider hedge assets included in the starting assets, either (1) including the asset cash flows in the projection model; or (2) replacing the hedge positions with cash and/or other general account assets in an amount equal to the market value of the hedge positions, as discussed in VM-21 Section 4.A.4.a.
   iii. Evaluations of the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, and other items that are likely to result in materially adverse results.
   iv. If residual risks and frictional costs are assumed to have a value of zero, a demonstration that a value of zero is an appropriate expectation.
   v. Any discontinuous hedging strategies modeled, and where such discontinuous hedging strategies contribute materially to a reduction in the stochastic reserve, any evaluations of the interaction of future trigger definitions and the discontinuous hedging strategy, including any analyses of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.
vi. Disclosure of any situations where the modeled hedging strategies make money in some scenarios without losing a reasonable amount in some other scenarios, and an explanation of why the situations are not material for determining the CTE 70 (best efforts).

vii. Results of any testing of the method used to determine prices of financial instruments for trading in scenarios against actual initial market prices, including how the testing considered historical relationships. If there are substantial discrepancies, disclosure of the substantial discrepancies and documentation as to why the model-based prices are appropriate for determining the stochastic reserve.

viii. Any model adjustments made when calculating CTE 70 (adjusted), in particular, any liquidation or substitution of assets for currently held hedges.

e. Error Factor ($E$) and Back-Testing – Description of $E$, the error factor, and formal back-tests performed, including:

i. The value of $E$, and the approach and rationale for the value of $E$ used in the reserve calculation.

ii. For companies that model hedge cash flows using the explicit method, as described in VM-21 Section 9.C.6.a, and have 12 months of experience, an analysis of at least the most recent 12 months of experience and the results of a back-test showing that the model is able to replicate the hedging results experienced in a way that justifies the value used for $E$. Include at least a ratio of the actual change in market value of the hedges to the modeled change in market value of the hedges at least quarterly.

iii. For companies that model hedge cash flows using the implicit method, and have 12 months of experience, as described in VM-21 Section 9.C.6.b, the results of a back-test in which (a) actual hedge asset gains and losses are compared against (b) proportional fair value movements in hedged liability, including:

a) Delta, rho and vega coverage ratios in each month over the back-testing period, which may be presented in a chart or graph.

b) The implied volatility level used to quantify the fair value of the hedged item, as well as the methodology undertaken to determine the appropriate level used.

iv. For companies that do not model hedge cash flows using either the explicit method or the implicit method, as described in VM-21 Section 9.C.6.c, and have 12 months of experience, the results of the formal back-test conducted to validate the appropriateness of the selected method and value used for $E$.

v. For companies that do not have 12 months of experience, the basis for the value of $E$ is chosen based on the guidance provided in VM-21 Section 9.C.7, considering the actual history available and the degree and nature of any changes made to the hedge strategy.

g. Safe Harbor for CDHS – If electing the safe harbor approach for CDHS, as discussed in VM-21 Section 9.C.8, a description of the linear instruments used to model the option portfolio.

g. Hedge Model Results – Disclosure of whether the calculated CTE 70 (best efforts) is below both the fair value and CTE 70 (adjusted), and if so, justification for why that result is reasonable, as discussed in VM-21 Section 9.D.

**VM-31 Section 3.F.12.c**

CTEPA – If using the CTEPA method, a summary including:

i. Disclosure (in tabular form) of the scenario reserves using the same method and assumptions as those used by the company to calculate CTE 70 (adjusted) as outlined in VM-21 Section 9.C (or the stochastic reserves.
following VM-21 Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6), as well as the corresponding scenarios reserves substituting the assumptions prescribed by VM-21 Section 6.C.

ii. Summary of results from a cumulative decrement projection along the scenario whose reserve value is closest to the CTE 70 (adjusted), as outlined in VM-21 Section 9.C (or the stochastic reserves following VM-21 Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6), under the assumptions outlined in VM-21 Section 6.C. Such a cumulative decrement projection shall include, at the end of each projection year, the projected proportion (expressed as a percent of the total projected account value) of persisting contracts as well as the allocation of projected decrements across death, full surrender, account value depletion, elective annuitization, and other benefit election.

iii. Summary of results from a cumulative decrement projection, identical to (ii) above, but replacing all assumptions outlined in VM-21 Section 6.C with the corresponding assumptions used in calculating the stochastic reserve.

VM-31 Section 3.F.16.a and Section 3.F.16.b

a. Investment Officer on Investments – A certification from a duly authorized investment officer that the modeled asset investment strategy, including any CDHS and any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, is consistent with the company’s current investment strategy except where the modeled reinvestment strategy may have been substituted with the alternative investment strategy, and also any CDHS meets the requirements of a CDHS.

b. Qualified Actuary on Investments – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any CDHS and any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6 was performed in accordance with VM-21 and in compliance with all applicable ASOPs.
TO: Dale Bruggeman (OH), Chair of the Statutory Accounting Principles (E) Working Group
FROM: Mike Boerner, (TX), Chair of the Life Actuarial (A) Task Force
DATE: February 4, 2021
RE: Clearly Defined Hedging Strategy (CDHS) Requirements

This referral has been provided to notify the Working Group of revisions to the Valuation Manual being considered by the Life Actuarial (A) Task Force during the 2/4/2021 Meeting on APF 2020-12, regarding CDHS. The proposed revisions in APF 2020-12 would require an update to SSAP 108 to maintain consistency between the Valuation Manual and the Accounting Practices and Procedures Manual.

APF 2020-12 under consideration by Life Actuarial (A) Task Force:

1) Moves the definition of a CDHS from VM-21 to VM-01;
2) Adds two criteria from the VM-20 CDHS definition that had not been in the VM-21 CDHS definition to the final definition in VM-01 that applies to both VM-20 and VM-21;
3) Requires that companies model hedging strategies that do not meet the definition of a CDHS under VM-21 if they increase TAR. However, it is noted in the Valuation Manual that this does not impact the treatment of such non-CDHS hedging strategies under SSAP 108.

For coordination between the Valuation Manual and the Accounting Practices and Procedures Manual, proposed edits to SSAP 108 are shown in the attached Appendix. Please contact NAIC staff of the Life Actuarial (A) Task Force with any questions on this proposal. Also attached is a copy of LATF APF 2020-12.

cc Julie Gann, Robin Marcotte, Dave Fleming, Reggie Mazyck, Pat Allison
Appendix

Proposed edit to SSAP 108, Paragraph 6.b.ii

Certification by a financial officer of the company (CFO, treasurer, CIO, or designated person with authority over the actual trading of assets and derivatives) that the hedging strategy meets the definition of a Clearly Defined Hedging Strategy within VM-01 and that the Clearly Defined Hedging Strategy is the hedging strategy being used by the company in its actual day-to-day risk mitigation efforts. This provision does not require reporting entities to use a hedging strategy in determining VM-21 reserves, nor does it require entities to use the special accounting provision within this standard. However, it does require reporting entities that use the special accounting provisions within this standard to certify that the hedging strategy within scope of this standard is a Clearly Defined Hedging Strategy and is reflected in the establishment of VM-21 reserves.

Proposed edit to SSAP 108, Paragraph 7

As identified in paragraph 2, eligibility for the special accounting provision within this standard is strictly limited to variable annuity contracts and other contracts involving certain guaranteed benefits similar to those offered with variable annuities that are reserved for in accordance with VM-21. This special accounting provision requires the reporting entity to engage in highly effective fair value hedges that follow a Clearly Defined Hedging Strategy, as defined in VM-01, meeting all required provisions of VM-21 allowing the reporting entity to reduce the amount of the Conditional Tail Expectation (CTE) Amount. In order to qualify as a Clearly Defined Hedging Strategy (which may be dynamic, static, or a combination thereof), the strategy must meet the principles outlined in VM-21, be in place (implemented) for at least three months', and shall at a minimum, identify:

a. Specific risks being hedged,
b. Hedge objectives,
c. Risks not being hedged,
d. Financial instruments that will be used to hedge the risks,
e. Frequency of measuring hedging effectiveness,
f. Metric(s) used for measuring hedging effectiveness,
g. Criteria that will be used to measure effectiveness,
h. Conditions under which hedging will not take place,
j. The individuals responsible for implementing the hedging strategy,
k. Areas where basis, gap or assumption risk related to the hedging strategy have been identified, and
l. The circumstances under which hedging strategy will not be effective in hedging the risks.

Proposed edit to SSAP 108, Paragraph 23.a

Discussion of hedged item, including information on the guarantees sensitive to interest rate risk, along with information on the designated hedging instruments being used to hedge the risk. Discussion of the hedging instruments shall identify whether a hedging instrument is a single instrument or portfolio, as well as information on the hedging strategy (including whether there have been changes in strategy from the prior reporting period, along with detailed information on the changes), and assessment of hedging effectiveness and compliance with the “Clearly Defined Hedging Strategy” of VM-01. Identification shall occur on whether the hedged item is intended to be fully hedged under the hedging strategy, or if the strategy is only focused on a portion of the liability characteristics or a portion of the interest rate sensitivity. Hedging strategies shall be identified as highly effective or not highly effective. If the strategy for a particular hedging relationship excludes a specific component of the gain or loss, or related cash flows, from the assessment of hedge effectiveness, details on the excluded components shall be disclosed.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
Dany Provencher, Appointed Actuary, Industrial Alliance group of companies

Title of the issue:
Asset collar when modeled reserve is negative

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

VM-20 Section 7.D.3

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

If for all model segments combined, the aggregate annual statement value of the final starting assets, less the corresponding PIMR balance, is

(a) less than 98% of the modeled reserve; or
   (i) 98% of the modeled reserve if modeled reserve is positive;
   (ii) 102% of the modeled reserve if modeled reserve is negative; or
(b) greater than the largest of:
   (i) 102% of the modeled reserve;
   (ii) the NPR for the same set of policies, net of due and deferred premiums thereon: and
   (iii) zero,

then the company shall provide documentation in the PBR Actuarial Report that provides reasonable assurance that the modeled reserve is not materially understated as a result of the estimate of the amount of starting assets.

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

If modeled reserve is negative, using assets corresponding to 100% of modeled reserve, would not fall within the asset collar.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.
The Life Actuarial (A) Task Force met Jan. 28, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Tynesia Dorsey, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Ben Bock and Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glenn Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); Scott A. White represented by Craig Chupp (VA); and James A. Dodrill represented by Tim Sigman (WV).

1. Discussed the Questions on the ESG Exposures

Scott O’Neal (NAIC) discussed items related to the economic scenario generator (ESG). He said the revised ESG timeline (see the Jan. 21 Task Force minutes) is posted on the Related Documents tab on the Task Force webpage. He said the public comment period for the Initial ESG Recommendation has been extended to March 7. He noted that an addendum was added to the exposure to indicate the extended comment period and provide clarifying information about the industry field test. He gave a reminder that ESG scenario statistics and reports, the scenario picker tool, and the stochastic exclusion test scenarios are exposed for a public comment period ending March 7.

Mr. O’Neal discussed the ESG question and answer (Q&A) document being developed by NAIC actuarial staff to capture and respond to the questions submitted by industry members. He said references to the submitted questions have been removed. The Q&A document will be posted on the Conning website. Randall McCumber (Lincoln Financial Group) asked when Conning expects to provide revised scenarios that fix the issue with the short end of the yield curve and when the actual scenarios for the Valuation Manual (VM)-20, Requirements for Principle-Based Reserves for Life Products, Stochastic Exclusion Ratio Test (SERT) will be available. Mr. O’Neal said NAIC staff and Conning are working to produce and evaluate additional scenario sets, and they will provide them as soon as possible. Dan Finn (Conning) said the SERT scenarios should be available in two weeks. Mr. McCumber asked if the deterministic reserve (DR) would still be linked to the same SERT scenario from the new ESG. Pat Allison (NAIC) said that is still the case. Mr. McCumber asked what scenario data companies will receive for the field test. Ms. Allison said it will probably include both the full set of 10,000 scenarios and a smaller subset of scenarios. Connie Tang (Prudential) asked if additional statistics and reports could be provided when the scenarios are released. Ms. Allison expressed openness to receiving feedback on specific statistics that industry members would like to see. Brian Bayerle (American Council of Life Insurers—ACLI) and Jason Kehrberg (American Academy of Actuaries—Academy) communicated that having additional documentation as soon as possible will facilitate the development of better questions from industry. Mr. Boerner said any existing documentation questions should be submitted as soon as possible.

2. Discussed Comments on the Criteria to Assess VM-20 YRT Reinsurance Solutions

Mr. Bayerle discussed the ACLI comment letter (Attachment Six-A) on the Criteria to Assess VM-20 YRT Solutions (Attachment Six-B). He said industry is supportive of allowing a prudent level of mortality improvement in the reserve projection. He said the ACLI believes that a principle-based yearly renewable term (YRT) solution should not be constrained by the current requirements of the Accounting Practices and Procedures Manual (AP&P Manual). He opined that changes to the AP&P Manual to address the YRT solution may be appropriate depending on the solution chosen.

Mr. Robinson said his comment letter (Attachment Six-C) provides feedback on the considerations listed in the solutions document. He suggested that a few of the criteria included in the considerations could be eliminated.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Brian Bayerle  
Senior Actuary  

December 15, 2020  

Mr. Mike Boerner  
Chair, NAIC Life Actuarial Task Force (LATF)  

Re: Criteria to Assess VM-20 Solutions for Modeling Non-guaranteed YRT Reinsurance  

Dear Mr. Boerner:  

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit the following comments on the exposed document “Criteria to Assess VM-20 Solutions for Modeling Non-guaranteed YRT Reinsurance”.  

ACLI recognizes the inherent challenges in addressing the level of the YRT reinsurance credit under a PBR framework. We appreciate the criteria document that the members of LATF have pulled together to assess potential solutions. We believe that some of the inherent complexity in addressing this issue is due to the level of margins, notably mortality margins, in the computation of the direct reserve. The results of the field study demonstrate the difficulty of clarity, consistency in interpretation, and application of any of the proposed solutions. Some companies favor a simpler solution; other companies support a solution that balances principles-based criteria and model complexity, considers the level of margins, and reflects an appropriate level of risk shared between the direct writer and reinsurer.  

Among the criteria outlined, industry is intrigued by the sixth criteria on consideration of mortality improvement beyond the valuation date. Industry supports a prudent level of mortality improvement in the reserve projection as a step to right-size the mortality margin. We support the effort of the joint SOA/Academy POG that is exploring a future mortality improvement methodology for use in projected reserves.  

Regarding the requirements outside of the Valuation Manual, we believe the point should make clear that changes to the APPM may be appropriate depending on the solution decided by regulators. As worded, it seems to suggest that the solution should fit into the confines of the accounting requirements, rather than appropriate reserve requirements informing the accounting requirements.  

We appreciate the consideration of our comments, and look forward to discussing on a future LATF call. Thank you.
Sincerely,

[Signature]

cc: Reggie Mazyck, NAIC
Criteria to Assess VM-20 Solutions for Modeling Non-guaranteed YRT Reinsurance

Below is a list of potential criteria that could be used to assess proposed VM-20 amendments regarding non-guaranteed YRT reinsurance.

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Potential APF selection criteria and other requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Level of prescription</td>
<td>o The APF should be principles-based, as defined in VM Section I, Overview of Reserve Concepts:                                                                                  • Uses one or more methods, or one or more assumptions, determined by the insurer pursuant to requirements of Model #820 and the Valuation Manual   • Reflects risks that are associated with the policies being valued capable of materially affecting the reserve  Note: The definition above does not preclude the use of appropriate guardrails or the use of a formulaic component.</td>
</tr>
<tr>
<td>2. Modeling complexity</td>
<td>o The APF should be practical to implement                                                                                 o The APF should be auditable                                                                 o The APF should allow simplified methods                                                                 o The APF should provide a safe harbor (e.g. use ( \frac{1}{2} c ), if a company has a de minimis amount of YRT reinsurance or the product type (e.g. term) produces a small modeled reserve credit. This is in the spirit of the definition of PBR as reflecting risks that are “capable of materially impacting the reserve.”</td>
</tr>
<tr>
<td>3. Variation in interpretations leading to variation in results</td>
<td>o The APF should contain an appropriate degree of alignment between the modeled reinsurance premiums paid by the ceding company and the modeled death claims paid by the assuming company.                                                                 o The APF should allow for variations in results due to treaty differences                                                                 o The APF should allow for variations in results from established relationships between a reinsurer and the ceding company that can be supported in the PBR Actuarial Report, and there should be appropriate application of ASOP 56 Section 3.1.6 (Assumptions used as Input)                                                                 o The APF should contain clear and unambiguous language                                                                 o The wording of the APF should not result in a wide range of company interpretations (i.e., there are clear requirements). It should produce similar reserve credits for two identical companies, (i.e. companies with the same products, inforce, mortality experience, reinsurance treaties, etc.).</td>
</tr>
<tr>
<td>4. Potential for asymmetry between assumed and ceded interpretation</td>
<td>o Although mirror reserving is not a VM-20 requirement (VM-20 Section 8.C.1), the APF should provide guidance on modeling non-guaranteed reinsurance features to be considered by both ceding companies and assuming companies that promotes a reasonable relationship between 1) the ceding company’s pre-reinsurance reserves vs. 2) the ceding company’s post reinsurance ceded reserve + the reserve held by the assuming company.</td>
</tr>
</tbody>
</table>

VM-20 Section 8.C.1: The company shall use assumptions and margins that are appropriate for each company pursuant to a reinsurance agreement. In such instance, the ceding and assuming companies are not required to use the same assumptions and margins for the reinsured policies.
5. Defined level of risk sharing

- The APF should contain provisions for appropriate risk sharing between reinsurance counterparties such that the level of assuming company loss acceptance produced is realistic and consistent with the projected scenario and treaty provisions.
- The approach for setting assumptions for non-guaranteed reinsurance elements under the APF should be consistent with the considerations in VM-20 Section 8.C.7. In addition to the economic environment considered in 8.C.7.b, the NGE assumptions should reflect other relevant moderately adverse conditions – including a moderately adverse mortality scenario.
- The APF should reflect that assumptions used in determining the modeled reserve should account for any actions that the counterparty has taken or is likely to take (VM-20 Sections 8.C.8 and 8.C.10).

VM-20 8.C.7: The company shall assume that the counterparties to a reinsurance agreement are knowledgeable about the contingencies involved in the agreement and likely to exercise the terms of the agreement to their respective advantage, taking into account the context of the agreement in the entire economic relationship between the parties. In setting assumptions for the NGE in reinsurance cash flows, the company shall include, but not be limited to, the following:
- a. The usual and customary practices associated with such agreements.
- b. Past practices by the parties concerning the changing of terms, in an economic environment similar to that projected.
- c. Any limits placed upon either party’s ability to exercise contractual options in the reinsurance agreement.
- d. The ability of the direct-writing company to modify the terms of its policies in response to changes in reinsurance terms.
- e. Actions that might be taken by a party if the counterparty is in financial difficulty.

VM-20 8.C.8: The company shall account for any actions that the ceding company and, if different, the direct-writing company have taken or are likely to take that could affect the expected cash flows of the reinsured business in determining assumptions for the modeled reserve.

VM-20 8.C.10: The company shall use assumptions in determining the modeled reserve that account for any actions that the assuming company has taken or is likely to take that could affect the expected cash flows of the reinsured business.

6. Consideration of mortality improvement beyond the valuation date

- Differences between the future mortality improvement assumption in the VM-20 prudent estimate mortality (currently not allowed) and any future mortality improvement assumption embedded in the current scale of YRT premiums should not be the primary driver to an undue reduction in the aggregate reserve for the business, that is the sum of the ceding company’s post-reinsurance reserve and the assuming company’s reserve.

7. Requirements outside the Valuation Manual

- The APF must coordinate and align with the Accounting Practices and Procedures Manual (APPM), or if needed, acknowledge that changes would be required:
  - The APF should consider SAP No. 61R
  - The APF should consider APPM Appendix A-791

8. Other considerations not shown above

- The APF should promote a level playing field (e.g. not favor large companies over small companies, not favor companies with YRT reinsurance over companies without YRT reinsurance)
- The APF should not encourage the use of captives
- The APF should not lead to market disruption (e.g. discouraging use of YRT reinsurance; greatly increasing cost to consumers)
- The APF should not discourage innovation
- The APF should handle all existing types of non-guaranteed reinsurance. While the most commonly considered non-guaranteed reinsurance feature

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Commented [OS1]: Consider changing 8.C.7.b economic environment in Valuation Manual to encompass more potential moderately adverse environments – such as a moderately adverse mortality environment.
| 9. Outstanding Questions | o Should negative reserve credits be avoided, i.e. should there be a floor on the reserve credit (such as ½ Cx)? |

is future YRT premium rates, other non-guaranteed features are also to be considered, such as non-guaranteed expense allowances.

o The APF should ideally contain language flexible enough to address emerging reinsurance structures that have not yet been seen in the marketplace.
**Criteria to Assess VM-20 Solutions for Modeling Non-guaranteed YRT Reinsurance**

Below is a list of potential criteria that could be used to assess proposed VM-20 amendments regarding non-guaranteed YRT reinsurance.

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| 1. Level of prescription | o The APF should be principles-based, as defined in VM Section I, Overview of Reserve Concepts:  
  ▪ Uses one or more methods, or one or more assumptions, determined by the insurer pursuant to requirements of Model #820 and the Valuation Manual  
  ▪ Reflects risks that are associated with the policies being valued capable of materially affecting the reserve  
  Note: The definition above does not preclude the use of appropriate guardrails or the use of a formulaic component.  
  
  **JR Comment:** If the APF pertains to DR and/or SR, then meeting this criterion is automatic. Consider deleting |
| 2. Modeling complexity | o The APF should be practical to implement  
  **JR Comment:** “Practical” is in the eye of the beholder.  
  o The APF should be auditable  
  **JR Comment:** “Auditable”, which pertains to the VM-31 report, depends on actuary’s ability to explain (to regulator’s satisfaction), which an APF can neither confirm nor deny.  
  o The APF should allow simplified methods  
  **JR Comment:** VM already has guidance on simplifications, which should be followed where applicable. Consider deleting.  
  o The APF should provide a safe harbor (e.g. use $\frac{1}{2}c$, if a company has a de minimis amount of YRT reinsurance or the product type (e.g. term) produces a small modeled reserve credit). This is in the spirit of the definition of PBR as reflecting risks that are “capable of materially impacting the reserve.”  
  **JR Comment:** Failure to provide a safe harbor should not lead to exclusion. |
| 3. Variation in interpretations leading to variation in results | o The APF should contain an appropriate degree of alignment between the modeled reinsurance premiums paid by the ceding company and the modeled death claims paid by the assuming company.  
  **JR Comment:** Add “from the perspectives of the ceding and assuming companies, respectively”.  
  Also, who decides “appropriate degree of alignment”?  
  o The APF should allow for variations in results due to treaty differences |
| 4. Potential for asymmetry between assumed and ceded interpretation | o Although mirror reserving is not a VM-20 requirement (VM-20 Section 8.C.1), the APF should provide guidance on modeling non-guaranteed reinsurance features to be considered by both ceding companies and assuming companies that promote a reasonable relationship between 1) the ceding company’s pre-reinsurance reserves vs. 2) the ceding company’s post reinsurance ceded reserve + the reserve held by the assuming company.  
VM-20 Section 8.C.1: The company shall use assumptions and margins that are appropriate for each company pursuant to a reinsurance agreement. In such instance, the ceding and assuming companies are not required to use the same assumptions and margins for the reinsured policies.  
JR Comment: Ceding and assuming companies are independent actors. An APF cannot ensure a reasonable relationship via principle-based calculations alone. |
|---|---|
| 5. Defined level of risk sharing | o The APF should contain provisions for appropriate risk sharing between reinsurance counterparties such that the level of assuming company loss acceptance produced is realistic and consistent with the projected scenario and treaty provisions.  
  o The approach for setting assumptions for non-guaranteed reinsurance elements under the APF should be consistent with the considerations in VM-20 Section 8.C.7. In addition to the economic environment considered in 8.C.7.b, the NGE assumptions should reflect other relevant moderately adverse conditions – including a moderately adverse mortality scenario.  
  o The APF should reflect that assumptions used in determining the modeled reserve should account for any actions that the counterparty has taken or is likely to take (VM-20 Sections 8.C.8 and 8.C.10)  
VM-20 8.C.7: The company shall assume that the counterparties to a reinsurance agreement are knowledgeable about the contingencies involved in the agreement and likely to exercise the terms of the agreement. |
### 6. Consideration of mortality improvement beyond the valuation date

- Differences between the future mortality improvement assumption in the VM-20 prudent estimate mortality (currently not allowed) and any future mortality improvement assumption embedded in the current scale of YRT premiums should not be the primary driver to an undue reduction in the aggregate reserve for the business, that is the sum of the ceding company’s post-reinsurance reserve and the assuming company’s reserve.

### 7. Requirements outside the Valuation Manual

- The APF should coordinate and align with the Accounting Practices and Procedures Manual (APPM), or if needed, acknowledge that changes would be required:
  - The APF should consider SSAP No. 61R
  - The APF should consider APPM Appendix A-791

**Comment: If APPM sets YRT reserve at \(1/2\) \(cx\), then any APF will require a change to APPM. (My hope is that the APPM change is to refer to VM rather than set out a specific formula, so future changes to VM don’t require APPM changes.)**

### 8. Other considerations not shown above

- The APF should not encourage the use of captives

**Comment: The use of captives is motivated by one or more outcomes. Consider identifying which specific outcomes are undesirable.**

- The APF should not lead to market disruption (e.g. discouraging use of YRT reinsurance; greatly increasing cost to consumers)

**Comment: Who is the judge?**

- The APF should not discourage innovation

**Comment: Who is the judge?**

---

Commented [OS1]: Consider changing 8.C.7.b economic environment in Valuation Manual to encompass more potential moderately adverse environments – such as a moderately adverse mortality environment.
| 9. Outstanding Questions | The APF should handle all existing types of non-guaranteed reinsurance. While the most commonly considered non-guaranteed reinsurance feature is future YRT premium rates, other non-guaranteed features are also to be considered, such as non-guaranteed expense allowances.

*JR Comment:* So far, we have only considered YRT. Let's nail down YRT and then expand later if needed.

| 9. Outstanding Questions | The APF should ideally contain language flexible enough to address emerging reinsurance structures that have not yet been seen in the marketplace.

*JR Comment:* If the structure has not been seen in the marketplace, a determination as to whether a particular APF is applicable doesn’t seem possible. Let's nail down YRT.

| 9. Outstanding Questions | Should negative reserve credits be avoided, i.e. should there be a floor on the reserve credit (such as ½ Cx)?

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The Life Actuarial (A) Task Force met Jan. 21, 2021. The following Task Force members participated: Texas, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Tynesia Dorsey, Vice Chair, represented by Peter Weber (OH); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Range represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); Scott A. White represented by Craig Chupp (VA); and James A. Dodrill represented by Tim Sigman (WV).

1. **Adopted its 2020 Fall Meeting Minutes**

Mr. Chou made a motion, seconded by Mr. Ostlund, to adopt the Task Force’s Dec. 3, 2020, minutes (see NAIC Proceedings – Fall 2020, Life Actuarial (A) Task Force). The motion passed unanimously.

2. **Heard an Update on IRC Section 7702**

Paul Graham (American Council of Life Insurers—ACLI) said the U.S. Congress passed the federal Consolidated Appropriations Act of 2020 at the end of December 2020. He said the Act included COVID-19 relief and changes to Section 7702 of the Internal Revenue Code (IRC), replacing the hard-coded 4% rate for the cash value accumulation test and the 6% rate used in the net single premium calculation for the guideline premium test with an indexed rate. He said that based on the revisions to Section 7702, a 2% life insurance nonforfeiture interest rate floor will be in place for 2021 and 2022, allowing a reduction in the maximum nonforfeiture interest rate to 3.75% for guarantee durations greater than 20 years. He said the ACLI will review the relevant wording in VM-02, Minimum Nonforfeiture Mortality and Interest, to fine-tune as needed. Mr. Boerner said that companies will have 12 months to comply with the 3.75% rate for states that provide the 12-month option as found in the Standard Nonforfeiture Law for Life Insurance (#808), Section 5cH(1). He said state insurance regulators should expect a surge in product filings.

3. **Heard a Status Report on the ESG and Exposed the Scenario Statistics and Reports, the Senior Picker Tool, and the Stochastic Exclusion Ratio Test Documents**

Pat Allison (NAIC) discussed the revised economic scenario generator (ESG) implementation timeline (Attachment Seven-A). She said the timing of the Executive Committee (EX) and Plenary anticipated adoption of ESG-related Valuation Manual amendments has been moved from the Summer National Meeting to the Fall National Meeting. She said the Life Insurance and Annuities (A) Committee and the Task Force target adoption dates have been adjusted accordingly. She discussed other target dates that have been adjusted to reflect the revised adoption dates. Brian Bayerle (ACLI) said the timeline is still aggressive and does not allow time for a second round of field testing, if necessary. Mr. Boerner said that if an additional field test is needed, the date for adoption of the Valuation Manual amendments will likely be pushed to 2022.

Ms. Allison said the initial ESG recommendations exposed for public comment in December will be revised to include an addendum indicating the types of feedback being sought. The exposure period was extended to March 7 without Task Force objection. Ms. Allison said the ESG field test is expected to run from June through August. NAIC staff will work with state insurance regulators to design the ESG field test. A request for field test participants will be distributed in the next few days. Companies will be asked to respond by March 1. Reports developed from field test results will be shared publicly.

Scott O’Neal (NAIC) shared that ESG-related exposures are posted on the Exposure tab of the Task Force web page. He said production scenario files and documentation will be available on the landing page of the Conning website. He said instructions for accessing these items are provided in the “Navigation to ESG Information” document (Attachment Seven-B) on the Related Documents tab of the Task Force web page. Mr. O’Neal and Dan Finn (Conning) discussed the Scenario Statistics and Reports
(Attachment Seven-C), the Scenario Picker Tool (Attachment Seven-D), and the Stochastic Exclusion Ratio Test (Attachment Seven-E) documents.

Mr. Boerner exposed the three documents for a 45-day public comment period ending March 7.

Having no further business, the Life Actuarial (A) Task Force adjourned.
## DRAFT FOR DISCUSSION

### ESG Implementation Timeline

<table>
<thead>
<tr>
<th>Number</th>
<th>Milestone</th>
<th>Status Key:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Target Date Range</td>
</tr>
<tr>
<td>1</td>
<td>NAIC Executive Committee approves ESG funding</td>
<td></td>
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<tr>
<td>2</td>
<td>Contract executed between NAIC and Conning</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>10/07 LATF/LRBC WG meeting on background &amp; deliverables</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Website development: Conning creates page to house prescribed scenarios, documentation, training materials, and tools, with access provided via link on NAIC website. Websites go live by</td>
<td></td>
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<tr>
<td>5</td>
<td>Documentation: Conning edits current documentation to include only information relevant to the Basic Data Set. Access to be provided by 12/31/20.</td>
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<tr>
<td>6</td>
<td>Education sessions: Conning presents ESG overview, calibration, parameters, and tools at LATF/Life RBC WG meetings</td>
<td></td>
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<tr>
<td>7</td>
<td>ESG modifications: Potential changes to calibration, parameters, and tools are discussed and exposed for comment at LATF/Life RBC WG meetings</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Parameter updates: Proposed frequency of updates is discussed and exposed for comment at LATF/Life RBC WG meeting</td>
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<tr>
<td>9</td>
<td>Conning's scenario reduction tool (to allow companies to choose a specific number of representative scenarios from a universe of 10,000) is discussed and exposed for comment at LATF/Life RBC WG meeting</td>
<td></td>
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<tr>
<td>10</td>
<td>Conning's calibration criteria (to determine whether stratified scenario subsets are sufficiently dispersed relative to the universe of 10,000 scenarios) are discussed and exposed for comment at LATF/Life RBC WG meeting</td>
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<tr>
<td>11</td>
<td>Conning's tool to generate scenarios for the VM-20 Stochastic Exclusion Ratio Test is discussed and exposed for comment at LATF/Life RBC WG meeting</td>
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<tr>
<td>12</td>
<td>Conning's tool to generate the VM-21 Company Specific Market Path scenario is discussed and exposed for comment at LATF/Life RBC WG meeting</td>
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<tr>
<td>13</td>
<td>Conning's tool to generate statistics, to be determined, on the scenario output, and validation reports (summarizing key characteristics of the Basic Data Set) are exposed for comment at LATF/Life RBC WG meeting</td>
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<tr>
<td>14</td>
<td>LATF/LRBC WG meetings to discuss comment letters received on exposures, and approve desired ESG and tool modifications for field testing</td>
<td></td>
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<tr>
<td>15</td>
<td>Conning makes ESG and tool modifications for field testing</td>
<td>Extension to Deadline</td>
</tr>
<tr>
<td>16</td>
<td>Preparation for reserve and capital field tests</td>
<td>Extension to Deadline</td>
</tr>
<tr>
<td>17</td>
<td>Conduct VM-20 and VM-21 industry field tests to determine life and VA reserve impacts and compile results</td>
<td>Field Testing</td>
</tr>
<tr>
<td>18</td>
<td>Conduct C3 Phase 1 and C3 Phase 2 industry field tests and compile results</td>
<td>Field Testing</td>
</tr>
<tr>
<td>-----------------------</td>
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<tr>
<td>24 <strong>LATF/LRBC WG meetings to discuss</strong> 1) aggregate field test results, 2) whether any calibration or parameter changes are needed based on the results (this timeline assumes none), and 3) potential VM and RBC instruction impacts, e.g., phase-in language</td>
<td></td>
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<tr>
<td>25 <strong>LATF exposes and adopts any necessary VM-20, VM-21, and VM-31 amendments</strong></td>
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<tr>
<td>26 <strong>NAIC A Committee adopts Valuation Manual amendments</strong></td>
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<tr>
<td>27 <strong>Conduct field test for fixed deferred and immediate annuities (assumed not to be required to implement new ESG for the 2022 VM since VM-22 framework is targeted for 2023)</strong></td>
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<tr>
<td>28 <strong>Conning updates documentation to reflect modifications adopted by regulators, and finalizes training materials</strong></td>
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<tr>
<td>29 <strong>Life RBC WG begins discussion on C3 Phase 1 and C3 Phase 2 instruction changes by 3/31/22 and exposes them for comment by 4/30/22</strong></td>
<td></td>
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<tr>
<td>30 <strong>Life RBC WG adopts C3 Phase 1 and C3 Phase 2 instruction changes by 6/30/22</strong></td>
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<tr>
<td>31 <strong>NAIC E Committee adopts RBC changes by 8/31/22</strong></td>
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<tr>
<td>32 <strong>NAIC Exec/Plenary adopts Valuation Manual amendments</strong></td>
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<tr>
<td>33 <strong>NAIC Exec/Plenary adopts RBC instruction changes by Dec. 2022</strong></td>
<td></td>
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<tr>
<td>34 <strong>Conning sets up process to run the basic data set as of each month-end and produce scenarios and related tools</strong></td>
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<tr>
<td>35 <strong>NAIC and Conning prepare websites for links to final documentation, training materials, scenarios, and tools</strong></td>
<td></td>
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</tr>
<tr>
<td>36 <strong>New ESG prescribed for VM-21 and VM-22 effective 1/1/22, and for C3 Phase 1 and C3 Phase 2 effective 12/31/22.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The intent would be to compare Conning's ESG against the AAA ESG throughout milestones 6-13.
Navigation to ESG Information

Life Actuarial (A) Task Force (LATF) Section of the NAIC’s Website

Link: https://content.naic.org/cmte_a_latf.htm

Navigation path: NAIC Home Page → Committees → Expand (+) button to the right of Life Insurance and Annuities (A) Committee → Life Actuarial (A) Task Force

ESG Exposure documents can be found on the tab labeled “Exposure Drafts”

Some of the reference materials related to the implementation effort for the ESG can be found in the tab labeled “Related Documents”

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Principle-Based Reserving (PBR) Section on the NAIC’s Website

Link: https://content.naic.org/pbr_data.htm

Navigation path: NAIC Home Page → Industry → click in the box for Principle-Based Reserving (PBR) → scroll down to the Economic Scenarios section

**ECONOMIC SCENARIOS**

Clicking on the link labeled “Economic Scenarios, Tools, Training Materials, and Documentation” will take you to the ESG landing page on Conning’s website. Related files, including files for the ESG Exposures, can be found on the landing page.
ESG Exposure 1/21/21: Scenario Statistics and Reports

A set of scenario statistics and reports (ESG Timeline Item #13) are being exposed for a public comment period. Please send comments to Reggie Mazyck (RMazyck@naic.org) by close of business March 7th, 2021.

Background and Monthly Process:
To help companies understand the range of results, Conning will produce statistics and reports based on the scenario output. These will be delivered with the scenario output by 4:00 PM Central Time on the first business day of the following month.

Simulation Summary
For the base model, there will be one Simulation Summary report for each column of the Basic dataset.

The Simulation Summary will include:

- a “fan chart” illustrating percentiles of the return distribution over time,
- a table of statistics at different periods in the projection, and
- a graph of the cross-sectional volatility throughout the projection.

The Simulation Summary reports for the 10,000 scenarios as of 12/31/19 exposed on December 18th, 2020 can be accessed via a link from the PBR section on the NAIC’s website to the ESG landing page on Conning’s website, or by clicking the following link directly below.

Simulation Summary as of 12/31/19

Note: The Simulation Summary currently contains separate reports for income and price and displays monthly returns. It may be preferable to:

- summarize just total returns, and/or
- summarize returns year over year, instead of monthly.

We are seeking feedback on this.
**Average Yield Summary**

To help envision the progression of yield curves, Conning will also produce a summary of average yields over time. (Note: To avoid over burdening the chart, the report will only include selected future time periods.)
**Additional Items**

Conning will also provide charts to help analyze other key items. For example, this may include information on yield curve inversion frequency, correlation (e.g. between different points on the yield curve, between equity and treasury returns, etc.), excess returns (e.g. excess returns over cash, equity returns over long treasury returns, long corporates over long treasuries etc.). The list of items can be extended as needed.

**Subset Reports**

Conning will produce reports which compare the scenario subset results to those from the entire distribution of 10,000 scenarios. For the Yields, the percentile results from the 10,000 scenarios would be compared to the percentiles taken from each subset and would be presented in a similar fashion to the graph below where the full set of GEMS scenarios is compared to AIRG scenarios. The actual subset reports will be available shortly via a link from the PBR section on the NAIC’s website to the ESG landing page on Conning’s website.
Request for Comments

Please send your comments to Reggie Mazyck (RMazyck@naic.org) by close of business March 7th, 2021. Comments are appreciated on any aspect of the reports, including:

- the format and useability of the reports,
- the desired statistics to be included,
- whether reports for total returns are more desirable than separate reports for income and price,
  and
- whether returns should be summarized on a monthly or annual basis.
ESG Exposure 1/21/21: Scenario Picker Tool

A Scenario Picker Tool (ESG Timeline Item #9) is being exposed for a public comment period. Please send comments to Reggie Mazyck (RMazyck@naic.org) by close of business March 7th, 2021.

**Background**

One of the components of the Academy Interest Rate Generator which needs to be replaced is the Scenario Picker Tool. This tool creates subsets (i.e., 50, 200, 500, and 1000 scenarios) from the full set of 10,000 scenarios, which can be used to reflect the full distribution.

Currently, if a scenario subset is used in reserve calculations, VM-20 prescribes use of the scenario picker tool but VM-21 does not. Applicable VM language is shown below.

VM-20 Section 7.G.2.c:

Use of fewer scenarios rather than a higher number of scenarios is permissible as a model efficiency technique provided that:

i. The smaller set of scenarios is generated using the scenario picker tool provided within the prescribed scenario generator, and

ii. The use of the technique is consistent with Section 2.G.

VM-21 Section 8.F:

1. For straight Monte Carlo simulation (with equally probable “paths” of fund returns), the number of scenarios should typically equal or exceed 1000. The appropriate number will depend on how the scenarios will be used and the materiality of the results. The company should use a number of scenarios that will provide an acceptable level of precision.

2. Fewer than 1,000 scenarios may be used provided that the company has determined through prior testing (perhaps on a subset of the portfolio) that the CTE values so obtained materially reproduce the results from running a larger scenario set.

3. Variance reduction and other sampling techniques are intended to improve the accuracy of an estimate more efficiently than simply increasing the number of simulations. Such methods can be used provided the company can demonstrate that they do not lead to a material understatement of results. Many of the techniques are specifically designed for estimating means, not tail measures, and could in fact reduce accuracy (and efficiency) relative to straight Monte Carlo simulation.

**Guidance Note:** With careful implementation, many variance reduction techniques can work well for CTE estimators. For example, see Manistre, B.J., and Hancock, G. (2003), “Variance of the CTE Estimator,” 2003 Stochastic Modeling Symposium, Toronto, September 2003.

4. The above requirements and warnings are not meant to preclude or discourage the use of valid and appropriate sampling methods, such as Quasi Random Monte Carlo (QRMC), importance sampling or other techniques designed to improve the efficiency of the simulations (relative to pseudo-random Monte Carlo methods).
**Scenario Picker Tool Methodology**

The proposed scenario picker tool follows the current Academy methodology (https://www.actuary.org/sites/default/files/files/esg/2009_ESWG_tool.zip) to create scenario subsets. Scenario subsets as of a given valuation date will contain the same scenarios for all users.

**Monthly Process**

Conning will run the Basic Data Set as of each month-end and produce the full set of 10,000 scenarios, along with four subsets containing 50, 200, 500, and 1,000 scenarios. This process will be completed in time to post the output by 4:00 PM Central Time on the first business day of the following month.

Note: Validation reports for the Basic Data Set and additional statistics will be delivered simultaneously with the scenario files. Users will be provided access to these items via a link from the PBR section on the NAIC’s website to the ESG landing page on Conning’s website.

Note: Rather than providing a scenario picker tool for users to run, Conning will deliver four scenario subsets (50, 200, 500, and 1,000) monthly. Users will not be able to pick a custom number of scenarios.

**12/31/2019 Scenario Subsets**

Scenario subsets produced as of 12/31/2019 will be provided shortly via a link from the PBR section on the NAIC’s website to the ESG landing page on Conning’s website. These will be selected from the full set of 10,000 scenarios included with the December 18th, 2020 exposure.

**Request for Comments**

Please send your comments to Reggie Mazyck (RMazyck@naic.org) by close of business March 7th, 2021. Comments are appreciated on any aspect of the scenario picker tool, such as:

1. The methodology used in the proposed scenario picker tool,
2. The number and sizes of the subsets to be produced, and
3. The format and usability of the output.
ESG Exposure 1/21/21: VM-20 Stochastic Exclusion Ratio Test (SERT) Scenarios

A methodology to produce the SERT scenarios (ESG Timeline Item #11) is being exposed for a public comment period. Please send comments to Reggie Mazyck (RMazyck@naic.org) by close of business March 7th, 2021.

**Background**
A tool must be developed to produce the prescribed set of 16 scenarios to be used for the VM-20 Stochastic Exclusion Ratio Test (SERT).

**Methodology**
The methodology used to produce the SERT scenarios is intended to follow the current AAA methodology (add link) except where the AAA methodology appears to differ from the scenario descriptions provided in VM-20 Appendix 1.E. For scenarios 13 through 16, the equity scenarios are described as “maintain the cumulative equity return at the 90% (or 10%) level”. The new SERT methodology follows this description. However, the equity returns for scenarios 13-16 produced in the AAA ESG have a delayed pop-up or pop-down.

The recommendation is to convert the Academy’s methodology into target percentiles for the three key variables: 1-Year and 20-Year Treasury Yields and Large Cap Total Return. Note that for scenario 10, the target percentiles are applied to the spread between the short and long rates. See the “Percentile Selection.xlsx” document below to find graphs and formulae describing how the Academy’s SERT methodology will be converted.

Going forward, Conning will take these percentiles and apply them to each projection’s 10,000 scenarios in order to produce 16 paths for these variables. For the additional Treasury Yields, Conning will apply the existing interpolation methodology. For the additional native GEMS equity models (i.e. Mid Cap, Small Cap and Aggressive US Equity), Conning will apply the percentiles from the Large Cap selection. These values will be entered into GEMS using the native User Path technology. This will allow GEMS to calculate all of the other items in both the Basic and Robust datasets conditional on these values. For example, the returns on the Long Inv Corp Bonds will include the following:

- Changes in Treasury Yields
- Expected changes in Corporate Spreads due to Treasury and Large Cap movements
- Expected transitions, defaults and recoveries due to current spread levels
12/31/2019 SERT Scenarios
SERT Scenarios produced as of 12/31/2019 will be provided shortly via a link from the PBR section on the NAIC’s website to the ESG landing page on Conning’s website. These SERT scenarios will be produced to align with the calibration used in the December 18th, 2020 exposure of 10,000 scenarios.

Request for Comments
Please send your comments to Reggie Mazyck (RMazyck@naic.org) by close of business March 7th, 2021. Comments that provide feedback on the methodology used, the output produced, the process to access the output, the format of the output files, or any other aspect of the exposure are welcome.
The Life Actuarial (A) Task Force met Dec. 17, 2020. The following Task Force members participated: Texas, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Tynesia Dorsey, Vice Chair, represented by Peter Weber (OH); Ricardo Lara represented by Ben Bock and Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Shannon Whalen represented by Vincent Tsang (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Tanji J. Northrup represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. Exposed the Goals Spreadsheet and Treasury Targets and Parameters Spreadsheet

Daniel Finn (Conning Inc.) provided a GEMS equity and corporate models overview presentation (Attachment Eight-A), which outlines the potential goals related to the models and gives background information and rationale for each goal. Pat Allison (NAIC) discussed a spreadsheet that lists the goals for U.S. Treasury rates, equity and corporate bond returns, and the market proxies used to produce fund returns. The spreadsheet includes the related decisions the Task Force is asked to make for each goal and the initial Conning recommendations for each decision. Connie Tang (Prudential) asked if information supporting the initial Conning recommendations will be made available to interested parties. Ms. Allison said access to the Conning basic data set as of Dec. 31, 2019, calibrated based on the initial set of recommendations, will be made available on the Principle-Based Reserving (PBR) page on the Industry tab of the NAIC website (https://content.naic.org/pbr_data.htm). Mr. Finn said the information will be updated over time to reflect interested party comments and Task Force decisions.

Mr. Boerner asked if any Task Force members objected to exposing the spreadsheet summarizing the decisions needed for the Treasury, equity and corporate models (Attachment Eight-B) and the spreadsheet showing the parameters of the Treasury Model (Attachment Eight-C) for a public comment period ending Jan. 31. There was no objection from Task Force members.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Overview of GEMS® Equity and Corporate Models
Dec. 17, 2020
Dan Finn, FCAS, ASA – Managing Director at Conning
Pat Allison, FSA, MAAA – NAIC Managing Life Actuary

Agenda

1. Presentation Approach
2. Reference Materials and Documentation
3. GEMS® Equity and Corporate Models: Potential Goals
4. Exposure for comments
Presentation Approach

1. Potential goals relating to the GEMS® Equity and Corporate Models are outlined.

2. For each goal:
   a. Background information is provided for educational purposes, along with an underlying rationale
   b. Similarities and differences between the Academy ESG and GEMS® will be discussed
   c. Items requiring decisions are highlighted, along with initial recommendations

Reference Materials and Documentation

The following materials are available on the LATF webpage (Related Documents tab):
https://content.naic.org/cmte_a_latf.htm
1. NAIC Technical Documentation - Corporate Bonds.pdf
2. NAIC Technical Documentation - Equity, DRAFT.pdf

ESG Background Information:
Economic Scenario Generators: A Practical Guide
https://www.soa.org/resources/research-reports/2016/2016-economic-scenario-generators/
Goal relating to equity and bond fund scenarios:

1. Returns should be provided for funds representative of those offered in U.S. insurance products

Rationale and Background: Funds must be mapped to proxy funds. Applicable VM-21 language is shown below. There is similar language in VM-20.

VM-21 Section 4.A.2 (second paragraph) - An appropriate proxy fund for each variable subaccount shall be designed in order to develop the investment return paths. The development of the scenarios for the proxy funds is a fundamental step in the modeling and can have a significant impact on results. As such, the company must map each variable account to an appropriately crafted proxy fund normally expressed as a linear combination of recognized market indices, sub-indices or funds.
### Equity Scenarios: AAA ESG compared to GEMS®

<table>
<thead>
<tr>
<th>AAA ESG Returns*</th>
<th>Market Proxy Used to Produce AAA ESG Returns*</th>
<th>Corresponding GEMS® Returns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversified Large Capitalized U.S. Equity</td>
<td>S&amp;P500 Total Return Index</td>
<td>S&amp;P 500</td>
</tr>
<tr>
<td>Diversified International Equity</td>
<td>MSCI-EAFE $USD Total Return Index</td>
<td>MSCI EAFE</td>
</tr>
<tr>
<td>Intermediate Risk Equity</td>
<td>U.S. Small Capitalization Index</td>
<td>Russell 2000</td>
</tr>
<tr>
<td>Aggressive Equity**</td>
<td>25% Emerging Markets, 12.5% NASDAQ, 62.5% Hang Seng</td>
<td>MSCI Emerging Market, NASDAQ</td>
</tr>
</tbody>
</table>

Additional GEMS® Returns: Russell Midcap (Diversified Midcap U.S. Equity)

The AAA ESG Model produces total returns.

GEMS® returns will be split between income and price, which can be combined to get total returns. Dividends are linked to the 10-Year Treasury yield and are negatively correlated with S&P price movements. Dividends do not affect total returns.

*Source: AAA LCAS C3 Phase II RBC for Variable Annuities: Pre-Packaged Scenarios January 2006

**The Academy Equity Model Aggressive Equity proxy is not meant to suggest a representative asset profile for this class but used merely to build an historic index with high volatility and sufficient history.

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### Bond Fund Scenarios: AAA ESG compared to GEMS®

<table>
<thead>
<tr>
<th>AAA ESG Returns*</th>
<th>Market Proxy used to produce AAA ESG Returns*</th>
<th>Corresponding GEMS® Returns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money Market</td>
<td>3 Month Treasury returns</td>
<td>Money Market</td>
</tr>
<tr>
<td>U.S. Long Term Corporate Bonds</td>
<td>U.S. Long Term Corporate Bonds</td>
<td>U.S. Long Term Investment Grade Corporate Bonds</td>
</tr>
<tr>
<td>Diversified Fixed Income</td>
<td>65% ITGVT + 35% LTCORP</td>
<td>GEMS® produces corresponding components</td>
</tr>
<tr>
<td>Diversified Balanced Allocation</td>
<td>60% Diversified Equity + 40% Fixed Income</td>
<td>GEMS® produces corresponding components</td>
</tr>
</tbody>
</table>


*Source: AAA LCAS C3 Phase II RBC for Variable Annuities: Pre-Packaged Scenarios January 2006
Decision to be made: Which returns should be included in the Basic Data Set?
Initial Recommendation: See table below. Fund returns in blue are new. For the other fund returns, there may be differences between the market proxies used for the AAA ESG and GEMS.

<table>
<thead>
<tr>
<th>Fund Returns</th>
<th>Market Proxy Used to Produce Fund Returns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversified Large Capitalized U.S. Equity</td>
<td>S&amp;P 500</td>
</tr>
<tr>
<td>Diversified International Equity</td>
<td>MSCI EAFE</td>
</tr>
<tr>
<td>Intermediate Risk Equity</td>
<td>Russell 2000</td>
</tr>
<tr>
<td>Aggressive Equity 1 (Name TBD)</td>
<td>MSCI Emerging Market</td>
</tr>
<tr>
<td>Aggressive Equity 2 (Name TBD)</td>
<td>NASDAQ</td>
</tr>
<tr>
<td>Diversified Midcap U.S. Equity</td>
<td>Russell Midcap</td>
</tr>
<tr>
<td>Money Market</td>
<td>Money Market</td>
</tr>
<tr>
<td>U.S. Short-Term Government Bonds</td>
<td>50/50 Blend of 1 and 5-year US Treasuries</td>
</tr>
<tr>
<td>U.S. Short-Term Investment Grade</td>
<td>50/50 Blend of 1 and 5-year maturities, 50/50 Blend of A and BBB</td>
</tr>
<tr>
<td>U.S. Intermediate Term Government Bonds</td>
<td>50/50 Blend of 5 and 10-year US Treasuries</td>
</tr>
<tr>
<td>U.S. Intermediate-Term Investment Grade</td>
<td>50/50 Blend of 5 and 10-year maturities, 50/50 Blend of A and BBB</td>
</tr>
<tr>
<td>U.S. Long-Term Government Bonds</td>
<td>50/50 Blend of 10 and 30-year US Treasuries</td>
</tr>
<tr>
<td>U.S. Long Term Corporate Bonds</td>
<td>50/50 Blend of 10 and 30-year maturities, 50/50 Blend of A and BBB</td>
</tr>
<tr>
<td>Diversified Fixed Income</td>
<td>65% Intermediate Term Government Bonds + 35% Long Term Corporate Bonds</td>
</tr>
<tr>
<td>Diversified Balanced Allocation</td>
<td>60% Diversified Large Capitalized U.S. Equity + 40% Diversified Fixed Income</td>
</tr>
<tr>
<td>High Yield Corporates</td>
<td>BB Rated Corporates</td>
</tr>
</tbody>
</table>

Note: The proposed set of equity returns allows direct mapping to MSCI Emerging Market, NASDAQ, and the additional Russell Midcap. This would eliminate a blended mix of indices for the Aggressive Equity investment category (VM-20 and VM-21 allow companies to create their own proxy fund blends).

Rationale for this goal: It is important to incorporate a historical period that captures an appropriate range of market dynamics while also being careful not to introduce bias into the generated scenarios.

AAA ESG compared to GEMS®:
- Generally, GEMS Equity model uses historical data back to 1994. The Corporate model uses historical data back to 1991
  - Impacted by large spike in 2008 Financial Crisis

Decision to be made: What historical period would regulators like to use?

Initial Recommendation: Use Conning’s current calibration.

*Source: CONSTRUCTION AND USE OF PRE-PACKAGED SCENARIOS TO SUPPORT THE DETERMINATION OF REGULATORY RISK-BASED CAPITAL REQUIREMENTS FOR VARIABLE ANNUITIES AND SIMILAR PRODUCTS, Revised 2006, AAA C-3 Phase II Working Group
Goal relating to the equity scenarios:

3. **The equity model should have stochastic volatility and the initial volatility should be updated frequently**

**Rationale for this Goal:** Most equity models have stochastic volatility because this allows for fatter tails in the scenario distribution. Without it, there would be little ability to produce big drops, such as the 2008 financial crisis or Black Monday.

The initial volatility should be updated frequently to reflect recent market movements.

**Background:** Chicago Board Options Exchange Volatility Index (VIX) reflects the market's estimate of future volatility. When the VIX is high, there tends to be more volatility in the short term.

**AAA ESG compared to GEMS®:** Both have stochastic volatility. However, in the AAA ESG, the initial volatility is not updated. So, each time a new set of scenarios is produced, the same starting level of volatility is used.

In GEMS, the initial volatility is updated based on recent market movements (usually during the last month). The process references the VIX and is consistent with how the parameter is simulated.

**Decision to be made:** Do regulators want to begin using a method to update the initial volatility level?

**Initial Recommendation:** Utilize GEMS stochastic volatility and process for continued parameter calibration.
AAA ESG compared to GEMS®: S&P 500 Total Return by Year with 9/30/20 Start

Impact of Changing Initial Volatility: GEMS®
S&P 500 Total Return, 12 Month Projections with 9/30/20 Start
Goal relating to the equity scenarios:

4. The ESG should have the ability to generate very large losses and gains in short periods of time (i.e. jumps)

Rationale and Background: Historically there have been short periods of large losses (e.g. 1Q 2020, Black Monday) as well as short periods with large gains (e.g. 2Q 2020). This suggests the need for a jump process.

AAA ESG compared to GEMS®:

- AAA ESG does not have a jump process.
- The GEMS jump process is based on historical data and a target for the fatness of the tails (e.g. how likely is a Black Monday). GEMS has more moments and can allow skew and kurtosis, which impact the fatness of the tails.

Decision to be made: How will the targets which impact the calibration of the jump process (e.g. skew and kurtosis) be expressed?

Initial Recommendation: Use Conning’s existing calibration.
Goal relating to the equity scenarios:

5. Equity scenarios need to reflect the possibility of a very long recovery after a period of losses

Rationale and Background: During certain periods of time after periods of recession or depression, there have been extended periods of equity market recovery. This is important to reflect in the scenarios due to the long-term nature of some insurance liabilities.

**AAA ESG compared to GEMS®:** Both the AAA ESG and GEMS can produce equity scenarios that exhibit low returns over an extended period of time. This is largely driven by volatility and the expected return. If there is enough volatility or if there are low enough expected returns, low for long scenarios will be produced.

As of 9/30/20, GEMS produced 34 scenarios with cumulative negative returns over a 30-year projection compared to 3 scenarios for the AAA ESG.

**Decision to be made:** None
Historical S&P 500 Returns

Cumulative Total Return
1929-1945

Projected S&P 500 Returns with a 9/30/20 Start Date
GEMS Scenarios with All Negative Cumulative Returns

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Goal relating to the equity scenarios:

6. There should be higher correlation in the tail scenarios between different equity indices

Rationale and Background: Historically, equity markets have been highly correlated in bad times. This is particularly important for reserve and capital CTE calculations.

Applicable VM-21 language:
VM-21 8.C.9: It is not necessary to assume that all markets are perfectly positively correlated, but an assumption of independence (zero correlation) between the equity markets would inappropriate exaggerate the benefits of diversification. An examination of the historic data suggests that correlations are not stationary and that they tend to increase during times of high volatility or negative returns. As such, the company should take care not to underestimate the correlations in those scenarios used for the reserve calculations.

AAA ESG compared to GEMS®:
• AAA ESG uses a static correlation matrix based on data going back to 1953
• GEMS is capable of producing returns that exhibit higher degrees of correlation in the tail scenarios. GEMS correlations are based on historical data going back mainly to 1994, and back to 1953 for some components.

Decision to be made: Should the Conning calibration be utilized or would regulators like to calibrate to a specific historical period?
Initial Recommendation: Use Conning’s existing calibration.

*Historical Correlation measured from 1979 to current
Goal relating to the equity scenarios:

7. There should be a link between equity returns and Treasury yields

Rationale and Background: It is difficult to see strong relationships between equities and Treasuries because the equity market is so volatile. However, investors typically demand equity returns in excess of those offered by risk-free assets to compensate for bearing risk. Today’s low yields imply lower equity returns.

AAA ESG compared to GEMS®:
- AAA ESG has no link between the equity returns and Treasury yields.
- GEMS links expected equity return to current short Treasury Yield
  - Produces different expected returns across start dates
  - Also makes them impacted by Treasury model’s mean reversion
  - This is a functional relationship, not a correlation

Decisions to be made:
1. Do regulators want a link between equity and treasury scenarios?
2. If so, are any changes to the functional relationship between equities and Treasuries desired?

Initial Recommendation: Use Conning’s existing calibration.

Impact of Changing Initial Treasury Yield
S&P 500 Total Return, 12 Month Projections with 9/30/20 Start

Prepared by Conning. Source: GEMS® Economic Scenario Generator scenarios
Goal relating to the bond fund scenarios:

8. The same model should be used to produce bond fund returns for the Basic and Robust Data Sets*, and the returns should reflect credit rating transitions, defaults, and dynamic spreads.

Rationale and Background:
- Use of the same model will ensure consistency between the total returns in the Basic and Robust Data Sets.
- The Basic and Robust Data Sets provide different levels of detail in the output.
  - The Basic Data Set includes only the total returns for the bond indices.
  - The Robust Data Set will provide details on the components (i.e., spreads, transitions, and defaults).

*The Basic Data Set will be prescribed. The Robust Data Set is optional and is available at a cost.

AAA ESG compared to GEMS®: The AAA ESG and GEMS Basic Data Set both provide total returns for bond indices.
- The AAA ESG total returns are linked to Treasuries, with a remainder modeled as a residual based on historical data
- GEMS Basic Data Set total returns will reflect modeled spreads, transitions, and defaults. Returns are expected to be between Treasuries and Corporate Yields minus a haircut.
  - “Haircut” typically reflects impact of defaults over a holding period
  - GEMS’ returns will also reflect up- and downgrades
  - Since downgrades tend to be more frequent and have a larger impact, the impact of including them will tend to exceed “haircut”

Decision to be made: Do regulators want any changes to the methodology used to generate credit rating transitions, defaults, and dynamic spreads?

Initial Recommendation: Use Conning’s existing calibration.
As Treasury yields increase, bond fund returns tend to decrease

As corporate spreads over Treasuries increase, bond fund returns tend to decrease
As downgrade probability increases, bond fund returns tend to decrease.

- Much of the difference between bars 1 and 3 is driven by higher volatility in the GEMS Treasury model.
- Bars 2 and 4 show the difference between the Corporate returns and Treasury returns.
Goal relating to the bond fund scenarios:

9. Separate yield curves should be generated by rating, and they should be linked to each other

Rationale and Background:
• Life insurers purchase a wide range of Corporate bonds.
• There are large differences in spreads between ratings.
• For blended bond funds (e.g., 50/50 blend of A/BBB), the total returns provided will be driven off blends of distinctly rated bonds. Bond returns by rating will not be provided in the Basic Data Set

Decision to be made: None
Goal relating to the bond fund scenarios:

10. The spread between Treasuries and corporate bonds should be stochastic

Rationale and Background: This allows spreads to gap out like they did during the 2008 Financial Crisis and 1Q 2020. The tail of the Corporate Bond returns is driven by these types of jumps. The magnitude of the jump has been significantly different between ratings.

This makes stochastic spreads very important for life insurer’s capital considerations, especially given the very large allocation to bond investments.

Decision to be made: None
Historical Corporate Spreads over US Treasuries (2008 Financial Crisis)

Projected GEMS Corporate Spreads over US Treasuries (single scenario)
Goal relating to the bond fund scenarios:

11. The ESG should include bond credit rating transitions and they should be dynamic

Rationale and Background: When Corporate spreads gap out, the market is indicating that these bonds have additional risk. The higher the spread, the more downward rating transitions.

- Increasing the volatility of spreads is helpful, but it won’t impact expected returns much in these situations
- Need to have some additional risk of downgrade (e.g., make an A Corporate “act” like a BBB Corporate)

Without this, the extra spread will simply lead to extra returns

Decision to be made: Do regulators want to change any of the assumptions driving spreads, rating transitions, and defaults?

Initial Recommendation: Use Conning’s existing calibration.

As spreads increase, downgrade probability increases
Summary of Goals

Goals relating to equity and bond fund scenarios:
1. Returns should be provided for funds representative of those offered in U.S. insurance products.
2. The ESG should be calibrated using an appropriate historical period.

Goals relating to the equity scenarios:
3. The equity model should have stochastic volatility and the initial volatility should be updated frequently.
4. The ESG should have the ability to generate very large losses and gains in short periods of time (i.e. jumps).
5. Equity scenarios need to reflect the possibility of a very long recovery after a period of losses.
6. There should be higher correlation in the tail scenarios between different equity indices.
7. There should be a link between equity returns and Treasury yields.

Goals relating to the bond fund scenarios:
8. The same model should be used to produce bond fund returns for the Basic and Robust Data Sets*, and the returns should reflect credit rating transitions, defaults, and dynamic spreads.
9. Separate yield curves should be generated by rating, and they should be linked to each other.
10. The spread between Treasuries and corporate bonds should be stochastic.
11. The ESG should include bond credit rating transitions and they should be dynamic.

ESG Exposure

The items listed below are exposed for a public comment period ending on 1/31/21.

1. A spreadsheet summarizing the decisions needed for the Treasury, equity, and corporate models (these were included in the 12/3/20 and 12/17/20 LATF presentations), along with an initial set of recommendations.
2. The entire Basic Data Set as of 12/31/19, calibrated based on the initial set of recommendations. This includes:
   • The full set of 10,000 interest rate scenarios
   • Equity and bond fund returns for the funds shown on slide 9.
   • Fan charts summarizing the interest rate scenarios
3. A spreadsheet showing the parameters of the Treasury model, and how targets (e.g., short and long-term mean reversion level, mean reversion speed) are converted into these parameters.

Notes regarding the materials:
• The initial set of recommendations and resulting scenarios represent a first cut at the types of changes that may be desired for the ESG. Additional modifications are expected based on comments received.
• These scenarios are a starting point for discussions, and are not intended to be used for an industry field test. A formal field test is currently planned in the March - May timeframe.
• Comments are appreciated on any aspect of the ESG.
<table>
<thead>
<tr>
<th>12/17/20 LATF Presentation Goal Number</th>
<th>Goal</th>
<th>Decision Needed</th>
<th>Initial Recommendation for Baseline ESG Calibration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Returns should be provided for funds representative of those offered in U.S. insurance products</td>
<td>Decision to be made: Which returns should be included in the Basic Data Set?</td>
<td>See Fund Returns Tab</td>
</tr>
<tr>
<td>2</td>
<td>The ESG should be calibrated using an appropriate historical period</td>
<td>What historical period would regulators like to use?</td>
<td>Use Conning’s current calibration.</td>
</tr>
<tr>
<td>3</td>
<td>The equity model should have stochastic volatility and the initial volatility should be updated frequently</td>
<td>Do regulators want to begin using a method to update the initial volatility level?</td>
<td>Utilize GEMS stochastic volatility and process for continued parameter calibration.</td>
</tr>
<tr>
<td>4</td>
<td>The ESG should have the ability to generate very large losses and gains in short periods of time (i.e. jumps)</td>
<td>How will the targets which impact the calibration of the jump process (e.g. skew and kurtosis) be expressed?</td>
<td>Use Conning’s existing calibration.</td>
</tr>
<tr>
<td>5</td>
<td>Equity scenarios need to reflect the possibility of a very long recovery after a period of losses</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>There should be higher correlation in the tail scenarios between different equity indices</td>
<td>Should the Conning calibration be utilized or would regulators like to calibrate to a specific historical period?</td>
<td>Use Conning’s existing calibration.</td>
</tr>
<tr>
<td>7</td>
<td>There should be a link between equity returns and Treasury yields</td>
<td>1. Do regulators want a link between equity and treasury scenarios? 2. If so, are any changes to the functional relationship between equities and Treasuries desired?</td>
<td>Use Conning’s existing calibration.</td>
</tr>
<tr>
<td>8</td>
<td>The same model should be used to produce bond fund returns for the Basic and Robust Data Sets, and the returns should reflect credit rating transitions, defaults, and dynamic spreads.</td>
<td>Do regulators want any changes to the methodology used to generate credit rating transitions, defaults, and dynamic spreads?</td>
<td>Use Conning’s existing calibration.</td>
</tr>
<tr>
<td>9</td>
<td>Separate yield curves should be generated by rating, and they should be linked to each other</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>The spread between treasuries and corporate bonds should be stochastic</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>The ESG should include bond credit rating transitions and they should be dynamic</td>
<td>Do regulators want to change any of the assumptions driving spreads, rating transitions, and defaults?</td>
<td>Use Conning’s existing calibration.</td>
</tr>
</tbody>
</table>
March 25, 2021

From: Rhonda Ahrens, Chair
The Longevity Risk (E/A) Subgroup

To: Mike Boerner, Chair
The Life Actuarial (A) Task Force

Subject: The Report of the Longevity Risk (A) Subgroup to the Life Actuarial (A) Task Force

The Longevity Risk (A) Subgroup has not met since the Fall National Meeting and is not likely to meet prior to the Summer National Meeting. A Drafting Group has been formed to contemplate reserve requirements related to pension risk transfer (PRT) and longevity reinsurance (LR) transactions that are more specific to the PRT reserves and are not solely related to the longevity component. The Subgroup will reconsider C-2 RBC for PRT products or LR transactions after reviewing the Drafting Group’s recommendations for resolution of identified issues.
March 25, 2021

From: Rhonda Ahrens, Chair
The Guaranteed Issue (GI) Life Valuation (A) Subgroup

To: Mike Boerner, Chair
The Life Actuarial (A) Task Force

Subject: The Report of the GI Life Valuation (A) Subgroup to the Life Actuarial (A) Task Force

The GI Life Valuation (A) Subgroup has not met since the Fall National Meeting and may meet prior to the Summer National Meeting depending on availability of subgroup members or their concerns. Otherwise, it is in a dormant/monitoring mode given that there have been no new known studies of GI Life mortality that could prove useful in formulating a new prescriptive requirement for the reserves for GI Life products. One direction we could go is to continue consideration of how to adopt the GI Life table but require companies with credible experience to use a credibility weighted mortality whether their experience is lower or higher than the table.
March 17, 2021

From: Fred Andersen, Chair
       The Experience Reporting (A) Subgroup

To: Mike Boerner, Chair
    The Life Actuarial (A) Task Force

Subject: The Report of the Experience Reporting (A) Subgroup to the Life Actuarial (A) Task Force

The Experience Reporting (A) Subgroup met on March 2, 2021 (see the attached minutes) to discuss plans for collecting life insurance mortality and policyholder behavior data using the NAIC as the statistical agent. There are plans to start developing mandatory reporting of variable annuity data and to continue work on evaluating actuarial aspects of accelerated underwriting in 2021.
The Experience Reporting (A) Subgroup of the Life Actuarial (A) Task Force met March 2, 2021. The following Subgroup members participated: Fred Andersen, Chair (MN); Perry Kupferman (CA); Wanchin Chou (CT); Nicole Boyd (KS); Rhonda Ahrens (NE); Bill Carmello (NY); and Mike Boerner (TX).

1. Received an Update on the Mortality Experience Data Collection Project

Pat Allison (NAIC) provided an overview of the mortality experience data collection project (Attachment Twelve-A). She said companies will be asked to submit data for the 2018 and 2019 observation years using 2020 and 2021 Valuation Manual requirements. Data for 129 companies, representing 90% of industry claims, is expected to be submitted by the Sept. 30 deadline. Ms. Allison said that VM-51, Experience Reporting Formats, lists the data items to be collected and the format to be used for record submission. She said validity checks and reasonability checks will be used to screen the data for accuracy. Jim Stinson (NAIC) discussed the internal NAIC reports, designed using the Tableau software, to facilitate the reasonability checks. Ms. Allison noted that the reasonability checks will include multiyear comparisons. She said data from the Kansas data call was used to help develop the validity and reasonability checks. She requested Subgroup feedback on the data screening approach.

An interested party asked whether each participating company will be asked to sign an agreement that outlines the details of the engagement. Dan Schelp (NAIC) responded that each company will execute a click agreement with the NAIC at the time of data submission. Ms. Allison discussed the multiple methods used to determine whether company submissions are acceptable. She noted the automated validity checks within the Regulatory Data Collection (RDC) tool. She said that the NAIC actuarial team will perform additional data validity checks. The results of the data validity checks will be shared with the submitting companies. Ms. Allison closed with a discussion of the responsibilities of participating companies.

Having no further business, the Experience Reporting (A) Subgroup adjourned.
Mortality Experience Data Collection
Project Update

Pat Allison, FSA, MAAA
Jim Stinson
Angela McNabb, ASA, MAAA
Amy Fitzpatrick

February 16, 2021
Agenda

- Data Collection Timeline
- Data items and format
- NAIC review process
- Reports to companies
- Company responsibilities
<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now</td>
<td>Companies may: 1) request exemptions or communicate exclusions (ongoing until 9/30/21), 2) review training materials, and 3) prepare submissions</td>
</tr>
<tr>
<td>Q2, 2021</td>
<td>Call for companies to submit data for 2018 and 2019 observation years using 2020/2021 Valuation Manual requirements. As of 2/1/21, we are expecting to collect data from 129 companies, representing approximately 90% of industry claims.</td>
</tr>
<tr>
<td>9/30/21</td>
<td>Deadline to submit data using the Regulatory Data Collection (RDC) tool. Automatic feedback on form and format data exceptions will be provided upon submission. Additional feedback will be provided within 30 days based on actuarial review.</td>
</tr>
<tr>
<td>12/31/21</td>
<td>Deadline for companies to make corrections</td>
</tr>
<tr>
<td>5/31/22</td>
<td>NAIC to submit aggregate experience data to SOA</td>
</tr>
</tbody>
</table>
## Data Items and Format

- Each record has 46 data items
- A single policy may have multiple records

We are expecting roughly 300 million records for the 2018 and 2019 observation years, combined.

### Experience Reporting Formats

#### Appendix 4: Mortality Data Elements and Format

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1-5</td>
<td>5</td>
<td>NAIC Company Code</td>
<td>Your NAIC Company Code</td>
</tr>
<tr>
<td>2</td>
<td>6-9</td>
<td>4</td>
<td>Observation Year</td>
<td>Enter Calendar Year of Observation</td>
</tr>
<tr>
<td>3</td>
<td>10-29</td>
<td>20</td>
<td>Policy Number</td>
<td>Enter Policy Number. For Policy Numbers with length less than 20, left justify the number, and blank fill the empty columns. Any other unique identifying number can be used instead of a Policy Number for privacy reasons.</td>
</tr>
<tr>
<td>4</td>
<td>30-32</td>
<td>3</td>
<td>Segment Number</td>
<td>If only one policy segment exists, enter segment number ‘1.’ For a single life policy, the base policy is to be put in the record with segment number ‘1.’ Subsequent policy segments are in separate records with information about that coverage and differing segment numbers.</td>
</tr>
</tbody>
</table>
Validity and Reasonability Checks

VM-50 Section 4.B.3: **Validity checks** are designed to identify:

a. Improper syntax or incomplete coding
b. Data elements containing codes that are not contained within the set of possible valid codes
c. Data elements containing codes that are contained within the set of possible valid codes but are not valid in conjunction with another data element code
d. Required data elements that are not populated

VM-50 Section 4.B.8: At a minimum, **reasonability checks** will include:

a. An unusually large percentage of company data reported under a single or very limited number of categories
b. Unusual or unlikely reporting patterns in a company’s data
c. Claim amounts that appear unusually high or low for the corresponding exposure
d. Reported claims without corresponding policy values and exposures
e. Unreasonable loss frequencies or amounts in comparison to ranges of expectation that recognize statistical fluctuation
f. Unusual shifts in the distribution of business from one reporting period to the next.
VM-50 Section 4.B.8 Part a. An unusually large percentage of company data reported under a **single or very limited number of categories**

Policy Distribution by BirthDate Year

<table>
<thead>
<tr>
<th>Company 1</th>
<th>Company 2</th>
<th>Company 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1900</strong></td>
<td><strong>1900</strong></td>
<td><strong>1900</strong></td>
</tr>
<tr>
<td><strong>1910</strong></td>
<td><strong>1910</strong></td>
<td><strong>1910</strong></td>
</tr>
<tr>
<td><strong>1920</strong></td>
<td><strong>1920</strong></td>
<td><strong>1920</strong></td>
</tr>
<tr>
<td><strong>1930</strong></td>
<td><strong>1930</strong></td>
<td><strong>1930</strong></td>
</tr>
<tr>
<td><strong>1940</strong></td>
<td><strong>1940</strong></td>
<td><strong>1940</strong></td>
</tr>
<tr>
<td><strong>1950</strong></td>
<td><strong>1950</strong></td>
<td><strong>1950</strong></td>
</tr>
<tr>
<td><strong>1960</strong></td>
<td><strong>1960</strong></td>
<td><strong>1960</strong></td>
</tr>
<tr>
<td><strong>1970</strong></td>
<td><strong>1970</strong></td>
<td><strong>1970</strong></td>
</tr>
<tr>
<td><strong>1980</strong></td>
<td><strong>1980</strong></td>
<td><strong>1980</strong></td>
</tr>
<tr>
<td><strong>1990</strong></td>
<td><strong>1990</strong></td>
<td><strong>1990</strong></td>
</tr>
<tr>
<td><strong>2000</strong></td>
<td><strong>2000</strong></td>
<td><strong>2000</strong></td>
</tr>
</tbody>
</table>

% of total number of boomers
VM-50 Section 4.B.8 Part c. Claim amounts that appear unusually high or low for the corresponding exposure

Company A (Expected View)

Face Amount, Death Claim Amount, and Death Claim Rate by Attained Age
Validity and Reasonability Checks: 
Results from the Kansas Data Call

• Data from the Kansas Data Call was analyzed and used for purposes of developing validity and reasonability checks

• Based on the checks developed to date, the following acceptance rates would result. We are seeking feedback from the Experience Reporting (A) Subgroup on the data screening approach we have developed

<table>
<thead>
<tr>
<th>Observation Year</th>
<th>Number of Companies</th>
<th>Number of records</th>
<th>% of records accepted</th>
<th>Number of company submissions accepted</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>7</td>
<td>5.9 million</td>
<td>94%</td>
<td>6</td>
</tr>
<tr>
<td>2016</td>
<td>32</td>
<td>24.1 million</td>
<td>83%</td>
<td>20</td>
</tr>
<tr>
<td>2017</td>
<td>22</td>
<td>17.1 million</td>
<td>69%</td>
<td>10</td>
</tr>
</tbody>
</table>

Count of companies by submitted years: 2016 only = 11; 2017 only = 3; 2015 & 2016 = 2; 2016 & 2017 = 14; all three years = 5

• The % of records and company submissions accepted by MIB is unknown
# Multiple Review Methods

<table>
<thead>
<tr>
<th>Review Method</th>
<th>Record</th>
<th>Company’s Submission</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Submission Company Code</td>
<td>X</td>
<td></td>
<td>RDC confirms submitter is authorized for company code and checks that only one company code is used throughout the file.</td>
</tr>
<tr>
<td>RDC Form and Format Checks</td>
<td>N/A</td>
<td>N/A</td>
<td>RDC provides feedback upon file submission. RDC will not reject records based on form and format checks. Example: smoker status is not a valid value.</td>
</tr>
<tr>
<td>Control Totals</td>
<td>X</td>
<td></td>
<td>This serves as an inclusion control, ensuring that all records intended to be submitted were received.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>VM-50 Section 4.B.2 requires each data submission to be balanced against a set of control totals provided by the company. At a minimum, these control totals shall include applicable record counts, claim counts, amounts insured and claim amounts. NAIC has developed a sample template for companies to use.</td>
</tr>
</tbody>
</table>
## Multiple Review Methods

<table>
<thead>
<tr>
<th>Review Method</th>
<th>Record</th>
<th>Company’s Submission</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconciliation to Annual Statement</td>
<td></td>
<td>X</td>
<td>This serves as an inclusion control, ensuring that only business in scope is submitted. VM-50 Section 4.B.3 requires companies to provide a reconciliation between submitted experience data and its statistical and financial data, along with an explanation of differences. NAIC has developed a sample template for companies to use.</td>
</tr>
<tr>
<td>Critical Indications from a Single Observation Year (e.g., 2019)</td>
<td>X</td>
<td></td>
<td>A record with one or more critical indications will be rejected. Example: issue age is missing.</td>
</tr>
<tr>
<td>Year-over-Year Critical Indications (e.g., 2019 vs. 2018)</td>
<td>X</td>
<td></td>
<td>Certain fields must remain consistent from year to year, and these are deemed to be critical. Example: issue date cannot change.</td>
</tr>
</tbody>
</table>
### Multiple Review Methods

<table>
<thead>
<tr>
<th>Review Method</th>
<th>Comments</th>
<th>Screen to decide whether to reject:</th>
<th>% of Accepted Records</th>
<th>Company Distribution for each of the 46 VM-51 Data Fields</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Scoring System</td>
<td>Each data exception in a record is assigned a score based on severity. A record is rejected if its total score exceeds a threshold (currently 100). Example of low severity: issue state is left blank. Example of high severity: preferred class structure on a substandard policy.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Company’s Submission</td>
<td>A company’s submission will be rejected if the % accepted records is below a threshold (currently 80%).</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Record</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
RDC Form and Format Screening

• The NAIC’s RDC tool will automatically perform data validity checks when a company uploads their mortality experience data

• The company will receive a report on the data exceptions identified by RDC shortly after they upload their experience data file. The company will then have the option to make corrections or submit their data.

Example:

<table>
<thead>
<tr>
<th>DATA EXCEPTION</th>
<th>RECORD COUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Basis is not a valid value (0-2)</td>
<td>15</td>
</tr>
<tr>
<td>Sample of records with this error: Policy – 1538426</td>
<td>Segment 1;</td>
</tr>
<tr>
<td></td>
<td>Policy – 2865470 Segment 3</td>
</tr>
<tr>
<td>Issue Date is before the Date of Birth</td>
<td>2</td>
</tr>
<tr>
<td>Sample of records with this error: Policy – 0286531</td>
<td>Segment 1;</td>
</tr>
<tr>
<td></td>
<td>Policy – 1693458 Segment 2</td>
</tr>
</tbody>
</table>
Actuarial Data Review

Identification of Critical Indications

• “Critical indications” are those that, if not corrected or confirmed, would leave a significant degree of doubt whether the affected data should be used (VM-50 Section 4.B.11)

• The NAIC will report “critical indications” to the company with an explanation of the unusual findings and their possible significance. Under the direction of the state insurance regulators, the NAIC will have reasonable flexibility to implement this, and may grade the severity of indications or simply identify certain indications as critical. (VM-50 Section 4.B.11)

Data Scoring System

• Where quality would not appear to be significantly compromised, the NAIC may use records with missing or invalid data if such invalid or missing data do not involve a field that is relevant or would affect the credibility of the report (VM-50 Section 4.B.5)

• For companies with a body of data for a state, line of business, product type or observation period that fails to meet these standards, the NAIC will use its discretion, with regulatory disclosure of key decisions made, regarding the omission of the entire body of data or only including records with valid data.
Reports to Companies

1. Cover Letter
2. Data Exception Distributions
3. Submission Summary spreadsheet – high level summary (record counts, rejected record counts, acceptance/rejection of submission)
4. Field Distributions
5. Rejected Record List
6. Detail file of all data exceptions with record identifier
Key Company Responsibilities

- There can be nothing known to be inaccurate or deceptive in the reporting (VM-50 Section 4.A.2).

- When the NAIC determines that the cause of an edit exception could produce systematic errors, the company must correct the error and respond in a timely fashion (VM-50 Section 4.A.3). Errors of a consistent nature are referred to as “systematic” (VM-50 Section 4.B.6).

- After notification of syntax errors and missing data elements, Companies are required to respond to the NAIC by submitting a corrected data file (VM-50 Section 4.B.1).

- Companies must respond to data exceptions identified by the NAIC as “critical” (VM-50 Section 4.B.11).

- Companies shall acknowledge and respond to reasonability queries from the NAIC. Corrections for critical indications shall be provided or, when a correction is not feasible, the extent and nature of the error shall be reported to the NAIC. (VM-50 Section 4.B.13)
March 15, 2021

From: Fred Andersen, Chair
The Indexed Universal Life (IUL) Illustration (A) Subgroup

To: Mike Boerner, Chair
The Life Actuarial (A) Task Force

Subject: The Report of the Indexed Universal Life (A) Subgroup to the Life Actuarial (A) Task Force

The Indexed Universal Life Illustration (A) Subgroup has not met since the Fall National Meeting. The Subgroup plans to meet again after any significant market developments following the adoption of *Actuarial Guideline XLIX-A, The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest Sold On or After November 25, 2020 (AG 49-A).*
April 8, 2021

From:  Pete Weber, Chair
       The Variable Annuity Capital and Reserve (E/A) Subgroup

To:    Mike Boerner, Chair
       The Life Actuarial (A) Task Force

Subject: The Report of the Variable Annuity Capital and Reserve (E/A) Subgroup to the Life Actuarial (A) Task Force

The Variable Annuity Capital and Reserve (E/A) Subgroup has not met since the Fall National Meeting. The Subgroup will monitor results of companies implementing the Variable Annuity framework and stand ready to consider any requests of the Task Force or the Life Risk-Based Capital (E) Working Group.
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met March 17, 2021. The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Ahmad Kamil, Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Nicole Boyd (KS); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello and Amanda Fenwick (NY); Rachel Hemphill and Karen Jiang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Voted to Use Two Risk Categories for VM-22 Valuations

Mr. Sartain said the consideration before the Subgroup is whether to have separate reserve categories for deferred and income annuities or have a single reserve category including both product types.

Mr. Carmello made a motion, seconded by Ms. Ahrens, to require two reserve categories for VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, with the requirement defaulting to a single risk category if the motion failed. The motion passed 6–4, with California, Kansas, Missouri, Nebraska, New York and Virginia in favor of the motion.

2. Tabled a Motion to Retain the VM-20 Integrated Risk Management Language

Ms. Lam made a motion, seconded by Mr. Leung, to retain the language in Section 5A of VM-20, Requirements for Principle-Based Reserves for Life Products, that allows for aggregation of products with significantly different risk profiles if the products are managed as part of an integrated risk management process. Ben Slutsker (American Academy of Actuaries—Academy) said the Academy Annuity Reserves and Capital Work Group (ARCWG) recommendation to have principles for aggregation was accompanied by a recommendation for having a single reserve category. He said, given the Subgroup vote for two reserve categories and the lack of clarity surrounding the integrated risk management language, the ARCWG favors removing the language in Section 5A from consideration for VM-22. Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI concurs with the ARCWG position. Ms. Hemphill said the language should be removed because it is unclear and may result in differing state insurance regulator interpretations and applications. Mr. Carmello and Ms. Ahrens said they believe the language serves as a useful regulatory tool.

Ms. Lam said she would be willing to amend the motion to include principles that might help clarify the VM-20 language but was unable to immediately offer specific language. Mr. Sartain suggested tabling the motion. Mr. Carmello made a motion, seconded by Ms. Lam, to table the motion. The motion passed unanimously.

3. Voted to Retain the VM-20 SERT Language

Mr. Sartain asked the Subgroup to consider whether the language in VM-20 Section 6.A.2.b.iv prohibiting the grouping of “contract types with significantly different risk profiles” when performing the stochastic exclusion ratio test (SERT) should be retained for VM-22.

Mr. Carmello made a motion, seconded by Ms. Hemphill, to retain VM-20 Section 6.A.2.b.iv language. The motion passed unanimously.

Having no further business, the VM-22 (A) Subgroup adjourned.
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met March 3, 2021. The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Ahmad Kamil and Thomas Reedy (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); Nicole Boyd (KS); William Leung (MO); Rhonda Ahrens (NE); Anna Krylova (NM); Amanda Fenwick (NY); Rachel Hemphill and Karen Jiang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. **Discussed Field Test Timing**

Mr. Sartain said the VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, field test is now scheduled from February 2022 through June 2022. He said the new date will necessitate a shift in the target date for the implementation of the revised VM-22 beyond January 2023 as initially planned. He said an additional change is the inclusion of capital considerations into the scope of the field test as a means of updating C-3 Phase 1. He noted that different conditional tail expectation (CTE) measures will be used for the annuity valuation and the C-3 Phase 1 efforts.

2. **Discussed the Product Scope of the Proposed ARCWG Framework**

Chris Conrad (American Academy of Actuaries—Academy) said the Academy Annuity Reserves and Capital Work Group (ARCWG) has determined that the scope of VM-22 should include both deferred and immediate annuities, on both an individual and group basis. He said account value-based deferred annuities, including single premium deferred annuities (SPDAs), flexible premium deferred annuities (FPDAs) and fixed indexed annuities (FIAs), will be in scope. Examples of the payout annuities that are in scope are single premium immediate annuities (SPIAs), pension risk transfers (PRTs), deferred income annuities (DIAs) and structured settlement contracts. He said the ARCWG has proposed excluding, for now, guaranteed investment contracts (GICs), stable value contracts and funding agreements from the scope of VM-22, primarily because those products exhibit less optionality and are tied to other regulations. He said the application of the framework to in-force business is still in question. Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI suggests exempting products that are expected to consistently pass the exclusion test. Mr. Sartain asked if the certification method of exclusion testing would sufficiently address the ACLI concern. Mr. Bayerle said the ACLI would prefer an approach similar to the Valuation Manual treatment of guaranteed issue (GI) products.

3. **Discussed Starting Assets and Discount Rates**

Mr. Conrad said the ARCWG recommends that the treatment of starting assets and discount rate follow the requirements of VM-21, Requirements for Principle-Based Reserves for Variable Annuities, with a safe harbor of using the new money re-investment rate for net asset earned rate (NAER) discount rate upon depletion of assets to avoid anomalous re-investment rates when the asset base is small. Mr. Bayerle said the ACLI agrees but would like the ARCWG to revisit making borrowing cost restrictions more principle-based. Mr. Tsang suggested using a higher cost of borrowing when assets are depleted. Mr. Conrad said the Academy’s proposal provides a guardrail that would allow a company the option to choose a more conservative rate. He said the issue may surface during the field test and can be addressed at that time.

4. **Discussed Allocation of Policy Reserves**

Ben Slutsker (Academy) said the method of reserve allocation affects the reporting categories in the annual financial statement, as well as per policy comparisons to cash value floor, which may have tax considerations. He said those considerations make allocation a sensitive issue. He said the ARCWG proposes a rigid approach that looks at the greatest present value of accumulated deficiencies (GPVAD) under a moderately adverse scenario. Ms. Hemphill said she is concerned about using a single scenario because it can be overly influenced by the business that drives the GPVAD for the CTE 70 scenario. She said the Texas Department of Insurance (TDI) recommended in its comment letter the disclosure of reserves for certain categories of business separately. She proposed using those same categories as the basis of an approach that could be scaled for the purpose of allocation. Mr. Slutsker said he will discuss the approach with the ARCWG. Mr. Sartain said he will add the disclosure proposal to the issues list.

Having no further business, the VM-22 (A) Subgroup adjourned.
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met on February 24, 2021. The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Elaine Lam, Ahmad Kamil and Thomas Reedy (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); Nicole Boyd (KS); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Anna Krylova (NM); Bill Carmello (NY); Rachel Hemphill and Karen Jiang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Discussed Adding Longevity Risk to the Exclusion Test

Mr. Sartain said the topic of adding longevity risk to the exclusion test will be added to the issues list for consideration during the field test.

2. Discussed Whether to Allow a Policy with a CDHS to be Eligible for Exclusion from the Stochastic Reserve

Mr. Sartain said that VM-20, Requirements for Principle-Based Reserves for Life Products, does not allow a policy supported by a clearly defined hedging strategy (CDHS) to be excluded from the stochastic reserve calculation. He said the reasons given on the Feb. 17 Subgroup call were: 1) the existence of a CDHS implies that there is material economic risk that should preclude the associated policies from being excluded from the stochastic reserve; and 2) the possibility that policies could be excluded due to hedging is discomforting. Ben Slutsker (American Academy of Actuaries—Academy) said the Academy believes that hedging programs should generally require stochastic reserve modeling, with the exception of hedging programs that are solely for the purpose of funding interest credits. He said fixed indexed annuities (FIAs) are examples of products that inherently have hedging in their designs, may not contain significant basis risk and should be allowed to use an exclusion test. Mr. Slutsker agreed to have the Academy look at the existing language in VM-21, Requirements for Principle-Based Reserves for Variable Annuities, to determine how it might be revised to address non-variable annuity hedging programs.

3. Discussed Reinvestment Guardrails

Chris Conrad (Academy) said that given the emphasis on the general account spread for fixed annuity products, the Academy is asking the Subgroup to revisit the existing fixed income guardrail of 50% A-rated bonds and 50% AA-rated bonds. He said the current split no longer reflects industry experience. He said the Academy recommends using the VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, credit quality distribution, which better represents average industry holdings. Ms. Hemphill said the Texas Department of Insurance (TDI) comment letter lists its concerns with the Academy recommendations. Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI supports the Academy recommendations. Steve Tizzoni (Equitable) said the Equitable comment letter expresses its belief that spread limits on reinvestments and existing assets ensure that there is no outsized reliance on excess credit spreads. He said Equitable’s letter suggests that the timing for contraction of spreads should be shortened.

Mr. Sartain asked for a brief history of the data supporting the VM-22 credit quality distribution categories. Mr. Conrad said the bond data was obtained for the Academy C-1 Working Group, which provided granular data from the years 2011 and 2013. Mr. Tsang said he supports guardrails that consider industry trends but believes boundaries are necessary. He suggested that members of industry develop a proposal for state insurance regulator consideration. Mr. Bayerle said the ACLI will work to develop proposals for both life and annuity products.

Having no further business, the VM-22 (A) Subgroup adjourned.
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met Feb. 10, 2021. The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Elaine Lam, Ahmad Kamil and Thomas Reedy (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Rachel Hemphill and Karen Jiang (TX); Tomasz Serbinowski (UT) and Craig Chupp (VA).

1. **Announced the Formation of a PRT Drafting Group**

Mr. Sartain said pension risk transfer (PRT) business is often originated in other countries, which raises the question of whether U.S. population tables are appropriate when reserving for PRT business. He said a regulator-to-regulator drafting group is being formed to look at this and other issues related to PRT business.

2. **Discussed Treatment of Longevity Risk for Exclusion Testing**

Ben Slutsker (American Academy of Actuaries—Academy) said the Academy proposed a stochastic exclusion ratio test (SERT) that had an up shock and a down shock to longevity for each of the 15 designated equity and interest scenarios. The greatest of the scenarios would become the numerator of the SERT. A baseline economic scenario without shocks would form the denominator of the SERT. Mr. Slutsker discussed a deterministic certification option, indicating that a stochastic run may not be necessary for contracts without policyholder options. He said a single deterministic scenario calibrated to a given conditional tail expectation (CTE) level may be sufficient. He said other criteria will have to be met.

Ms. Hemphill said that mortality is just one consideration to be addressed by the exclusion test; other risks will also need to be considered. She noted hedging as one such item that will need to be given consideration.

Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI believes that it is not clear whether including longevity as one of the considerations for stochastic testing makes sense. He said applying margins to the mortality assumptions might be a better way to capture longevity risk.

Ms. Hemphill said the Texas Department of Insurance (TDI) has concerns about having fixed SERT parameters that apply universally. She suggested incorporating a principle-based materiality threshold into the SERT determination.

3. **Discussion of Whether to Allow Risks to Be Combined**

Mr. Sartain asked if interest rate risk and longevity risk should be netted together. Mr. Slutsker said the intent of netting the two risks is to reflect any covariance that may exist. He said it also facilitates implementation. Mr. Tsang said he prefers keeping blocks of business separate to allow for a meaningful understanding of the specific risks in each block. Mr. Slutsker said that approach is similar to the deterministic certification option. He said the option does not eliminate the stochastic calculation but requires it less frequently.

4. **Discussed Exclusion Testing for FIAs**

Mr. Tsang discussed the reasoning for not allowing products for which a company uses a clearly defined hedging strategy (CDHS) to qualify for the exclusion tests. Mr. Sartain noted that if the VM-20, Requirements for Principle-Based Reserves for Life Products, language were to be used, fixed indexed annuities (FIAs) without guaranteed minimum benefits would not be eligible for exclusion.

Having no further business, the VM-22 (A) Subgroup adjourned.
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met Feb. 3, 2021. The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Elaine Lam, Ahmad Kamil and Thomas Reedy (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); William Leung (MO); Seong-min Eom (NJ); Bill Carmello (NY); and Rachel Hemphill and Karen Jiang (TX).

1. **Discussed the Standard Projection Amount**

   Mr. Sartain said that a straw poll taken during Subgroup’s Jan. 27 showed that most Subgroup members prefer limiting the standard projection amount (SPA) to a disclosure item instead of a stochastic reserve floor. He asked if anyone who prefers the SPA as a disclosure item had an alternative stochastic reserve floor in mind other than the cash value. No Subgroup members indicated a desire for an alternative stochastic reserve floor.

2. **Discussed Aggregation Principles**

   Mr. Sartain said the final straw poll taken during the Subgroup’s Jan. 27 meeting asked whether the language governing the criteria for aggregating products based on the management of associated risks should remain principle-based, be more prescriptive or be removed from the framework. He said that members voted, by a small margin, to remove the language. Ben Slutsker (American Academy of Actuaries—Academy) said the Academy initially thought that the language would apply to exclusion testing criteria, as well as reserving. He said now that the Subgroup is separately considering aggregation criteria for exclusion testing, the Academy believes the language is not needed for reserving. Brian Bayerle (American Council of Life Insurers—ACLI) and Mr. Leung agreed with the Academy’s position. Ms. Lam said she considers the reserve categories as guardrails and believes the principles may still be necessary within the specific categories. Mr. Sartain said the principles are vague and might be difficult to regulate. He asked why it should matter whether their risks are managed together if the products can offset one another. Ms. Hemphill said if there are clear reasons that certain products should not be aggregated, that might be an indication that additional reserve categories are needed. Mr. Kamil said the principles should be further investigated before deciding they are not needed. Mr. Sartain said discussion will continue, with the goal of a final vote on the issue in March.

3. **Discussed Aggregation for Exclusion Testing**

   Mr. Sartain said that VM-20, Requirements for Principle-Based Reserves for Life Products, requires that the types of business aggregated for exclusion testing must be similar. He asked if participants agreed that the VM-20 concept should be included in the language of the principle-based reserving (PBR) for non-variable annuities. Mr. Slutsker said the Academy would not be opposed to application of the principle for the purpose of exclusion testing but would be cautious about the granularity of exclusion testing restrictions. Mr. Sartain said the VM-20 language would be used as it currently stands. Ms. Hemphill said she is supportive of that position.

4. **Discussed Other Exclusion Testing Issues**

   Mr. Bayerle said the ACLI comments include a suggestion that a materiality threshold be considered. He said decisions on the exclusion test should be deferred until they can be informed by the results of the field test. He said the ACLI has concerns about the inclusion of longevity risk in exclusion testing. He said products that will always be able to pass the exclusion tests should possibly be considered out of scope. He said the exclusion tests should be performed at the highest level of aggregation.

Having no further business, the VM-22 (A) Subgroup adjourned.
Valuation Manual (VM)-22 (A) Subgroup
Virtual Meeting
January 27, 2021

The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met Jan. 27, 2021. The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); Nicole Boyd (KS); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Russell Toal (NM); Bill Carmello (NY); Rachel Hemphill and Karen Jiang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Discussed the Academy’s Preliminary Framework Elements for Fixed Annuity PBR

The Subgroup discussed whether the Valuation Manual should have separate categories for deferred annuities and payout annuities. Ms. Ahrens advocated for having separate chapters in recognition of the inherent differences in the products. She said the benefits of risk diversification between the products is not a sufficient reason for aggregating the products for the purpose of calculating reserves. She said she is comfortable with the two reserve categories for now. She noted that additional categories can be developed later if the necessity arises due to product innovation. Mr. Yanacheak said he is less concerned with whether deferred annuities and payout annuities are separated by chapters. He said he is more interested in developing principles that would apply appropriate reserving treatment for the two types of annuities.

The Subgroup took a straw poll on whether there should be one or two reserve categories for reserve aggregation. The vote was seven to five in favor of two reserve categories. Mr. Sartain noted that two or more categories could be required for disclosure.

A second straw poll asked whether the standard projection amount (SPA) should be used as a reserve floor or solely for disclosure. The vote was seven to four in favor of limiting the SPA to a disclosure item. The Subgroup agreed that multiple reserve categories should be required for the SPA.

The final straw poll asked whether the language governing the criteria for aggregating products based on the management of associated risks should remain principle-based, be more prescriptive, or be removed from the framework. There were four votes for removal of the principle-based language, three votes for retaining the principle-based language, and three abstentions. No members voted for more prescriptive language. Two members left the call prior to voting.

Having no further business, the VM-22 (A) Subgroup adjourned.
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met Jan. 20, 2021. The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); Nicole Boyd (KS); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Russell Toal (NM); Bill Carmello (NY); Rachel Hemphill and Karen Jiang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Discussed the Academy’s Preliminary Framework Elements for Fixed Annuity PBR

Mr. Sartain explained that the Subgroup will address the subject of aggregation separately for stochastic reserve calculation and exclusion testing. Ben Slutsker (American Academy of Actuaries [Academy] Annuity Reserve and Capital Work Group—ARCWG) said the aggregation of the reserve categories when calculating the conditional tail expectation (CTE)-70 allows for the benefits of diversification. He said the ARCWG favors a single reserving category for reserve aggregation. He said the ARCWG is open to considering multiple categories for exclusion testing aggregation.

Mr. Sartain asked commenters to discuss the portions of their comment letters that address aggregation. John Robinson (MN) said his comment letter (Attachment Twenty-One-A) reflects his concern with the auditability of non-variable annuity reserves if deferred and payout annuities are aggregated for the stochastic reserve calculation. Mr. Sartain asked if the auditability goal could be accomplished with additional disclosures. Mr. Robinson responded that even if the deferred and payout reserve numbers are separately disclosed, reconciling them to the aggregate reserve will be difficult. He reiterated his preference for at least two reserving categories. He also said the criteria applicable to aggregation requires greater definition.

Ms. Hemphill said page 3 of her comment letter (Attachment Twenty-One-B) addresses aggregation. She said the aggregation principles in the preliminary framework will lead to inconsistent aggregation across companies. She said aggregation based on the principles would be difficult to review. She said she favors full aggregation with disclosures of the aggregation benefits and application of the standard projection amount (SPA).

Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI comment letter (Attachment Twenty-One-C) supports the principle that aggregation be consistent with how assets are managed. He said the ACLI supports full aggregation with the disclosure of aggregation benefits.

Steve Tizzoni (Equitable) said the Equitable comment letter (Attachment Twenty-One-D) supports full aggregation because it reflects the diversification benefits that are core to the insurance industry. He also spoke in favor of the SPA as a floor to ensure that the diversification benefit is not excessive.

A straw poll was taken on the issue of whether, in the determination of the stochastic reserve, all fixed annuity business should be aggregated as a single reserving category with the appropriate disclosures or more than one reserving category should be required for aggregation. The Subgroup member voting was split evenly, with both options getting six votes. Mr. Sartain, the chair, refrained from voting. He suggested that given the tightness of the voting, the topic requires more discussion.

Having no further business, the VM-22 (A) Subgroup adjourned.
I thank and congratulate the ARWG for this work.

I would like to comment on Slide 21, Aggregation. The principles enunciated are focused on how the business is managed, particularly from a risk perspective. However, the fourth ARWG Pillar of Objective (Slide 2) calls for a process that is, among other things, auditable. I believe it is the intent of ARWG that the pillars on Slide 2 supersede the principles on Slide 21.

“Auditable” means that the process must facilitate the explanation of results. Qualified Actuaries performing reserve calculations have traditionally determined and analyzed reserves by product type. This facilitates insight and understanding when explaining results to company management, regulators and other actuaries.

The promise of PBR is that reserves will be “right-sized” relative to the company’s circumstances. In the case of deferred annuities, the conventional wisdom is that the current formula-based methods produce worst-case-scenario, overly conservative reserves; so, right-sizing the reserves should decrease them. On the other hand, the current formula-based reserves for immediate annuities generally understate reserves due to the lock-in of out-dated mortality and interest assumptions; so, right-sizing the reserves should increase them. In order to determine whether this promise has been kept, it will be necessary to determine reserves for deferred annuities and immediate annuities separately.

I therefore call for the establishment of VM-22 Reserving Groups which would, at a minimum, separate deferred and immediate annuities.

Thank you.

John Robinson FSA, FCA, MAAA
DATE: December 14, 2020
TO: Bruce Sartain, Chair of VM-22 (A) Subgroup
SUBJECT: ARWG Preliminary Framework Oct 2020

Dear Bruce:

We appreciate the opportunity to provide input on the draft ARWG framework.

- Reinvestment mix should represent the fixed income assets portion of the investment portfolio and reflect moderately adverse conditions.
- A CDHS concept is needed for future hedge modeling that materially reduces the reserves.
- Aggregation requirements and methodology should be clearly defined.
- The design of the exclusion test needs to be clarified and consider non-tested risk factors that may have material impact on the ratio test results, e.g., liability assumptions and hedging. The ratio test passing criteria should be linked to the company’s definition of materiality, with the VM-22 threshold as a guardrail.
- The implication of the PBR reserve framework on the non-PBR capital framework needs to be carefully considered.
- Comments for other topics.

Sincerely,

Karen Jiang, FSA, MAAA, FRM
PBR Actuary
Actuarial Office, Financial Regulation Division

Rachel Hemphill, Ph.D., FSA, FCAS, MAAA
PBR Team Lead
Actuarial Office, Financial Regulation Division

CC Ben Slutsker, ARWG at Benjamin_Slutsker@newyorklife.com
Reggie Mazyck, NAIC at Rmazyck@naic.org
Mike Boerner, TDI at mike.boerner@tdi.texas.gov
Appendix I: Requested Feedback

Reinvestment Mix

- Comments on setting limits to the current VM-22 credit quality mix? (Slide 11)

A few considerations about the credit quality mix:

1. It should represent the fixed income investment portion of the asset portfolio only. The current proposal does not do this.
2. It should be based on the latest industry data. The current proposal does not do this.
3. Using a typical industry average fixed income portfolio mix is not conservative as needed for the purpose of setting reserves. A mix with higher credit quality to reflect moderately adverse conditions is more appropriate. The current proposal does not reflect this.
4. Currently VM-22 adds additional conservatism not in the current VM-22 credit quality mix by applying a 25 bps spread deduction; without this spread deduction in the ARWG framework, the credit quality mix should be more conservative. The current proposal does not reflect this.
5. It is desired that the same reinvestment mix guardrail be used for all of VM-20, VM-21 and the new VM-22.

Additionally, we are concerned with the grading from short-term spreads to long-term spreads, especially if there is an option to liquidate currently held hedges (as there is in VM-21) reflecting an unrealistic gain in reinvestments when short-term spreads are high as of the valuation date. This problem currently applies to VM-20 and VM-21. Additionally, it may be preferable to use a net yield pickup based criteria for reinvestments instead of a guardrail based on a specific asset mix, which would reduce implementation constraints seen to date with the alternative reinvestment guardrail.

Index Credit Hedging Treatment

- Does modeling breakage hedge expense seem reasonable? (Slide 13)

1. Generally speaking, a CDHS concept (having a clearly documented hedging strategy and program) is needed in cases where reserves or TAR is materially reduced. Future hedging should not materially reduce reserves or TAR if it is not a CDHS. For straightforward types of hedging, the CDHS documentation should only be simpler to provide.

2. Hedge breakage expense assumptions
   a. The wording of “hedge expense” should not be confused with the hedge cost that needs to be reflected in the projections of the hedge modeling.
   b. Are both sources of error reflected here - error in the hedging itself, and error in the ability to accurately model it? Should we be separately considering the two limitations
to make sure they are both clear: 1) the real-world hedging error and 2) the modeling error in reflecting the future hedging? Current error factor discussions seem muddied.

c. The 1% minimum allowed seems too low. How does the 1% breakage expense reflected as either the additional expense or the reduced investment income compare with the 5% reduction in future hedging benefit for reserves (on a PV basis)? A low E factor needs to be supported by the projected hedge gain and loss being within a close range of 100%. VM-21 suggests a range of 80-125%. With a lower minimum expense/error factor should this range be narrowed? The rationale for a lower expense factor (having lower basis risk and greater effectiveness) suggests that we should expect a back-testing result much closer to 100%.

d. The same requirement should be considered for VM-20 hedge modeling which are mostly index credit hedging for IUL products.

3. Will companies request special hedge accounting treatment from SAPWG similar to SSAP 108?

Aggregation

- Any additional principles to include, or suggested modifications or elaboration of principles listed? (Slide 21)
- Impose differences in aggregation for exclusion testing purposes? (Slide 22)

We have a concern with this approach, related to concern with the current VM-20 approach. We are not seeing clear or consistent approaches to what "managed together" or "managed separately" means. A fuzzy requirement here is no requirement. If the point is to generally allow full aggregation, why even have a fuzzy requirement? What are examples that one could not reasonably argue should be aggregated?

Consider 1) an aggregation certification to demonstrate that the aggregation chosen meets the requirements if they can be clearly defined and/or 2) if companies change aggregation method they need to get domicile commissioner's approval.

We prefer VM-22 define standard reserving categories for all exclusion test, stochastic reserve and standard projection amount purposes. There should be no aggregation of products with significantly different risk profiles for exclusion testing, but for products that fail the test and go through the SR/SPA calculation, aggregation is allowed but with the reserves for each individual category and the aggregation benefit being disclosed. SR and SPA are supposed to use the same aggregation method.

Ideally, for aggregation benefit disclosure, we would review these product categories:

- Deferred Annuities
  - FIAs with GLBs
  - FIAs without GLBs
FDAs with GLBs
FDAs without GLBs

Payout Annuities
- SPIAs
- PRT
- DIAs
- SSC

If this is too granular in some instances, a minimum split would include fixed annuities with GLBs, fixed annuities without GLBs, SPIAs, PRT, and then all others.

Exclusion Testing
- Include testing of longevity risk in the ratio test? (Slide 25)
- Provide potential deterministic calculation option for policies with limited optionality? (Appendix V)

1. Mortality Component: The shocks should be the greater of the mortality margin magnitude or the fixed amount determined by the ARWG.

2. Threshold: The threshold needs to consider the absolute dollar amount and be linked to the company's materiality standard. A group of contracts should not be able to be excluded from VM-22, if the aggregate variability under the scenarios exceeds the company's materiality standard. That is, if the economic or mortality variability is material based on the company's definition of materiality, then the SERT is failed. Then, any fixed threshold selected by the ARWG for the SERT (e.g., 6%) is just a "guardrail" on the company's defined materiality standard. Note that this is more principles based than an SERT with a fixed threshold and also applies as a critique of VM-20's SERT.

3. Impact of Liability Assumptions: Will exclusion testing include SPA results as part of the 16 scenario calculations, if it is for more than disclosure? If you are also being excluded from the SPA, the SPA needs to be somehow reflected as part of the SERT process. What if over-optimistic liability assumptions (e.g., policyholder inefficiency) drive passing the SERT? This reflects a difference between VM-20 and VM-21. VM-20 has a SERT but does not exclude you from the NPR. VM-21 has an SPA but no SERT.

4. Impact of Hedging: VM-20 does not allow a company to exclude a group of policies for which there is one or more CDHS from stochastic reserve requirements. VM-22 does not require policies with hedging to automatically fail exclusion test. Again, what if hedging drives the passing of the SERT? What hedging documentation and support is needed if a SERT is performed that relies on hedging? Should results be shown with and without hedging? This is another place where we should consider alignment between the two VM chapters.
Allocation Methodology

- Any alternative methods to consider? (Slides 27-28, Appendix III)

A single scenario won’t capture individual policy risk. Neither will immediate election.

Reserve allocation is not only for tax purpose but also for RBC purpose. For products that calculate RBC using a factor-based approach, reserves need to be allocated if they are aggregated with other products that use a different RBC approach, e.g., C3P1. Need to seek input from the LRBC group. One conservative approach is to use the standalone reserves for RBC purpose.
Appendix II: Additional Feedback

Reflecting Risk in Moderately Adverse Conditions (Slide 2)

Just a note that this is fundamentally different than the PBR approach for economic scenarios. A CTE(70) reflects both less than moderately adverse and more than moderately adverse scenarios, in an average. For non-economic variables that are not stochastically modeled we may partition particular risks or scenarios into moderately adverse and beyond moderately adverse, which needs to be reflected in capital only. But the more we move to stochastic modeling of risks, reserves will just generally be increased by tail risk, both above and below a “moderately adverse” threshold, with a lesser sensitivity to deeper in the tail risks or scenarios than capital.

Potential Management Actions (Slide 2)

Potential management actions reflected should only be those that, at a minimum, are pursuant to documented company policy and are not inconsistent with historical actions.

Principles (Slide 2)

Speaking of Principles, will VM-22 cite/follow the VM-21 principles?

SPA (Slide 3)

Note that the SPA is actually neither formulaic nor a floor. The types of arguments you present here against the SPA seem to be wrestling with the ghosts of past requirements (the old standard scenario), rather than addressing the living, evolving requirements of the Valuation Manual. In contrast, a CSV floor is both formulaic and a prescriptive floor. Is the ARWG opposed to a CSV floor?

Existing PBR Frameworks (Slide 3)

For each deviation from the current VM-21, please outline whether: 1) a deviation is necessary due to unique product features or risk characteristics between the policies in scope (describe) or 2) a deviation from the current VM-21 is proposed that would be a better requirement for both VM-21 and VM-22 (describe). Similar comparisons to VM-20 are also preferable.
Implementation Period (Slide 9)

We need to be mindful of potential inconsistency between reserves and capital. If a principles-based capital framework is not completed (updated), then interim revisions may be needed if the amount of business under the new VM-22 framework is material.

Can a company wait until the end of the transition period to start PBR, but then apply PBR to the issues from the transition period?

Mortality (Slide 15)

What does "unsupported judgment" mean? Why should there be any unsupported judgment? Let’s not perpetuate this phrasing.

Will international lives also use 2012 IAM Basic Table with Scale G2? This may not be appropriate in many cases.

What number of years of future improvement will be used?

Policyholder Behavior (Slide 16)

Margins: VM-20 and VM-21 have analogous requirements - both start with individually determined margins and then one substitutes margins based on the joint distribution while the other discusses a correlation adjustment to reflect the joint distribution. Should these be harmonized, along with VM-22?

VM-22 reporting should quantify the impact of all margins, showing the effect with and without. VM-22 reporting should also ensure A/E’s are provided with E being the anticipated or best estimate assumption.

NGEs (Slide 18)

Will this reflect company policy and past actions, and also include any legal and/or reputational considerations in determining anticipated NGEs?

Joint Payouts & Supplemental Benefits (Slide 19)

For VA products with joint payouts and/or supplemental benefits, similar requirements should be added to VM-21.
Reinsurance (Slide 20)

VM-20 requires that treaties be modeled either 1) if they qualify for credit for reinsurance or 2) if modeling them reduces surplus. This is a reasonable treatment, but VM-21 does not have the 2nd. We recommend the VM-20 treatment for VM-22. This should also be considered for VM-21.

Materiality

The ARWG will need to address materiality and simplifications/approximations/modeling efficiency techniques. If you are basing on VM-21, note that VM-21 is missing a consideration of the aggregate impact of all approximations and so does not have an assurance that the reserve is not materially understated in aggregate.

VM-20 has the requirement that individual approximations don't bias reserves downward. This provides some assurance about the aggregate impact, but is not the same as a consideration of the aggregate impact. Possibly all three should have a consideration of the aggregate impact.

Exclusion Test Methodology (Slide 25)

Item h) – Appendix V is mainly about the “certification” but not how the DR itself will be calculated. It may be reasonable to just do DR calculations in some situations, but this depends on the methodology/scenarios.

Allocation (Slide 28)

Again, need to consider non-US mortality.

VM-31 Disclosures (Slide 29)

What certifications will be included for the VM-22 reporting? Will they follow VM-20 or VM-21?

Hedge back-testing should be shown for the full time period current strategy has been in place. This should also apply to VM-21. VM-20 may also need additional details.
CTE(70)

For products with market value adjustment, CTE(70) needs to be floored at cash surrender value with MVA which varies by scenarios.

For products that do not have a cash surrender value, it is recommended that VM-22 use a "working reserve" concept, similar to VM-21 Section 3.G requirement.
Brian Bayerle  
Senior Actuary

December 18, 2020

Mr. Bruce Sartain  
Chair, NAIC VM-22 (A) Subgroup 

Re: ARWG Preliminary Framework

Dear Mr. Sartain:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit the following comments on the exposed presentation deck on the Academy Annuity Reserve Working Group (ARWG) preliminary framework for fixed annuity PBR.

ACLI is appreciative of the hard work of the ARWG in developing the framework for fixed annuity PBR. We believe the framework is going in the right direction, and we offer the following feedback on the five directed topics and additional comments:

1. Reinvestment Mix

We believe the 50% A / 50% AA fixed income reinvestment guardrail should be revisited, and regulators should consider using a more industry-consistent reinvestment mix in VM-22 and other principle-based reserves. As credit spreads and defaults are already prescribed, this level of conservatism in the reinvestment mix should not be necessary. Revisiting this reinvestment restriction for all products was also flagged for LATF review by the NAIC staff letter and a VM-21 drafting note. We would support the use of VM-22 credit quality mix as asset mix limitation for VM-22 reinvestment assets as proposed by the ARWG as it is reasonably industry-consistent for products in scope of VM-22. The VM-22 spread reflects an average credit quality of approximately ‘A’ to ‘A-’, which we believe is representative of fixed annuity market pricing and investing practices and is therefore an appropriate level for principle-based reserving.

2. Index Credit Hedging Treatment

We agree that modeling hedge breakage seems reasonable and appropriate. The index credit hedge breakage simplification seems like a potentially reasonable option for those that do not model their hedge program explicitly or manage market risks from their products more holistically; we believe it should be an optional simplification and not a requirement. We believe, however, that the proposed 1% floor factor can be too low in some instances. Static and dynamic hedges should
have different breakage expenses as dynamic hedges should have a higher minimum breakage expense given the inherent uncertainty of hedge income actually realized. For static hedging strategies, whereby the replicating portfolio of financial instruments is purchased at the index segment inception, a 1% floor on the hedge cost expressed as a percentage of the interest credited might be reasonable (but should be tested to determine whether another level is more appropriate). However, for dynamic hedging strategies that do not lock in the index crediting amount at segment inception, a 1% floor is likely too low. Depending on the strategy, we believe a floor approaching the 5% floor within VM-21 would be appropriate, as such strategies show more hedge ineffectiveness during periods of market stress than static hedge programs.

Additionally, we believe that there should be more discussion on the treatment of reflecting management actions in the reserve, such as index credits, caps, and management of hedge gains and losses and defaults.

3. Aggregation

Aggregation should be primarily driven by how assets are managed, since that is how the company views risk/return trade-offs. Companies already aggregate for other purposes including C3P1 and asset adequacy; the economic scenario that actually materializes will be the same for all business, and it would not make sense to calculate results separately and hold reserves for a product assuming rates spike and reserves for another product assuming that the same rates simultaneously decrease. Deviating from the level assets are managed would require arbitrary and/or complex asset allocations across blocks of business that could distort reserves, even if the allocation method is consistent over time. Concerns about shorter duration / less risky cash flows running off seem like a reserve pattern issue (rather than what is currently appropriate) that would be better addressed in the ORSA. Alternately, there could be an aggregation benefit disclosure.

4. Exclusion Testing

We support the inclusion of an exclusion test in VM-22, as well as a materiality threshold similar to the Life PBR Exemption. We believe that exclusion testing thresholds should be set based on the risks and field test results, rather than by a priori views about what should or should not pass. We do not believe longevity risk should be included in the ratio test for all products; rather, the test should limit its focus on ALM mismatch risk. Products with well-matched portfolios and only longevity risk do not necessarily need to be tested stochastically and should be able to pass the exclusion tests. Longevity risk can then be handled through the margins embedded in prescribed mortality assumptions. Alternatively, we support including a deterministic reserve option to handle payout contracts with longevity risk, similar to that described in the appendix of the exposure.

If there are products that regulators believe should always pass any exclusion test, regulators should consider if these products should be out of scope for VM-22. Where appropriate, it may be worth considering whether exclusion testing requirements could be simplified or potentially removed for certain products that regulators expect to pass to reduce the extra work of doing both an exclusion test and creating the required PBR documentation for these products (or as previously suggested something akin to the VM-20 Life PBR Exemption). This product-specific
guidance could also be addressed within VM-22 (for example, if FIAs without withdrawal benefits fall back on AG35, consider making the Iowa practice for indexed products part of VM-22).

5. Allocation Methodology

We believe there should be flexibility around allocation, so long as it supports an acceptable tax reserve. We do not believe VM-22 allocation needs to be more prescriptive than VM-21. VM-22 should allow for company discretion to develop an allocation method consistent with VM-21. For example, for many products using NAR (value of benefits above CSV) would generally produce a similar result as the proposed methodology, without requiring additional complexity/runs. We also note that tracking GPVAD on a seriatiol basis is extremely complex and functionally impossible for companies who use crunched/cluster models.

6. Scope

ACLI believes that whether a product falls under VM-21 or VM-22 should depend on the nature of the risk. Based on the nature of the risk, we believe that hybrid annuities and many structured annuity designs would be covered by VM-21. Further, we believe that funded and unfunded longevity reinsurance should fall within the scope of the existing VM-22. Finally, several categories from the existing VM-22 Scope section are not included in the slides (e.g., Supplementary Contracts, CDA’s); we would like to understand if certain products were deliberately excluded at this time from the potential regulatory framework.

7. Timeline

Target effective dates will need to be reconsidered if inforce business is included in VM-22 on either an optional or mandatory basis. The timeline should consider a later effective date for inforce than new business, alignment with C-3 Phase 1, and other considerations. Companies have a wide variety of systems and VM-20 and VM-21 processes do not necessarily support VM-22 required processes, so it is likely to require a very large build. A scope limited to new business would simplify the build because it would reflect the much smaller universe of products currently being developed and offered.

8. Discount Rates and Starting Assets

We believe there should be alignment of discount rates and starting assets to the VM-21 methodology. We recommend revisiting borrowing cost restrictions (e.g., to avoid anomalies and/or be more principles-based) and aligning the approach across all products. During VM-21 development, regulators deliberately aligned asset requirements with VM-20, but ultimately the framework deviated from this and added the borrowing cost restriction to VM-21. The NAIC staff letter from the VA subgroup work and a VM-21 guidance note flagged this for future LATF review for all products.

9. Mortality
We believe mortality should follow a principles-based approach consistent with VM-21 rather than the more prescriptive approach in VM-20. We believe it is appropriate for consistency of alignment between annuity products. Mortality curves in the “no data” case or for credibility weighting and mortality improvement should reflect appropriate experience / assumptions – including product differences, appropriate granularity, geographic / country differences, etc. It would be inappropriate to merely rely on VA mortality, and rather should consider updated SOA reports and studies (e.g., upcoming fixed deferred, individual payout, group payout, etc.).

10. VM-31 Disclosures

We have the following comments on the disclosure recommendations:

- General Account Assets: A full reserve calculation may not be necessary. Appropriately documented simplifications that demonstrate why the reinvestment restrictions are more conservative should still be allowed (e.g., similar to VM-20, Section 2.G) if it is clear the reinvestment restriction will dominate instead of requiring 2 runs.
- Hedging: It is not clear whether the full contract fair value comparison is useful for VA, and it seems potentially even less useful for fixed annuities (e.g., for a plain vanilla FIA with hedged index credits).
- Dynamic Policyholder Behavior: This requirement seems redundant with existing requirements to provide rationales for assumptions and could perhaps be addressed with a guidance note.

We appreciate the consideration of our comments, and look forward to discussing on a future call. Thank you.

Sincerely,

[Signature]

cc: Reggie Mazyck, NAIC
EQUITABLE

DATE: December 14, 2020
TO: Bruce Sartain, Chair, NAIC VM-22 (A) Subgroup
FROM: Aaron Sarfatti, Chief Risk Officer; Steve Tizzoni, Head of Actuarial Regulatory Affairs
SUBJECT: Equitable Comments on Fixed Annuity Principles Based Reserve (PBR) Proposal

Equitable appreciates the opportunity to comment on the Academy Annuity Reserve Working Group’s (ARWG) proposed Fixed Annuity PBR framework. Below are our views on two key aspects of the framework: (1) reinvestment mix; and (2) aggregation of reserves. The remainder of our views are appropriately captured in the ACLI comment letter.

**Reinvestment Mix:**
The VM-22 subgroup requested feedback on the reinvestment mix used in the fixed annuity PBR framework. The ARWG recommends use of reinvestment assumptions that are in line with VM-20 and VM-21 but proposes using a reinvestment mix of 5% Treasury, 15% AA, 40% A, and 40% BBB instead of the current 50%/50% blend of A/AA corporate bonds used in VM-20/21.

Equitable believes credit spread limits for both reinvestment and existing investments are central guardrails to assure the integrity of principle-based reserving. Aggregate or portfolio wide credit spread caps are necessary to ensure the asset portfolio reserve aligns with market pricing for interest-sensitive liabilities and hence ensures balance sheet resilience. Individual security credit spread caps ensure individual assets at high risk of impairment reflect appropriate default loss expectations, although may not be necessary in the presence of prudent portfolio-wide spread caps.

Equitable supports the use of a VM-22 credit quality mix as the aggregate credit spread cap for reinvestment assets as proposed by the ARWG. The VM-22 spread reflects an average credit quality of approximately ‘A’ to ‘A-’, which we believe is representative of fixed annuity market pricing and investing practices and is therefore an appropriate level for principle-based reserving.

In addition to applying the VM-22 based credit spread cap to reinvestment assets, Equitable supports application of such a cap to existing assets. Such a limit would ensure reserves do not rely on excessive amounts of credit spread in excess of industry investment and pricing practices. A credit spread cap applied at the individual security level could also be considered to ensure appropriate default loss expectations are used for assets at high risk of impairment. We think an appropriate level for such a cap would be the lower limit of investment grade credit, approximately BBB.

In addition to extending the scope of credit spread caps within the VM-22 framework, Equitable believes the ARWG should consider shortening the proposed four-year period over which current credit spreads grade to long term spreads to no longer than one year. In practice, we see credit spreads reverting to long term averages significantly faster than four years. In the event of elevated credits, such as in the 2008-2009 financial crisis or the 2020 COVID-19 crisis, we do not believe reserves should reflect benefits of historically wide spreads on assets that the company does not yet own. It is reasonable for reserves to
reflect a benefit from such elevated spreads once the assets are purchased and on the company’s balance sheet.

As an example, consider the March 2020 valuation date. Spreads were extremely elevated at that time, and, under a four-year grading construct, a company would be required to reflect elevated spreads in its reinvestments for the next three years -- a significant reserve benefit as of March 2020. Instead, over the next few months, spreads quickly compressed towards the long-term average, and by June 2020, most of the reserve reduction from elevated spreads at the March 2020 valuation date had reversed without any offsetting benefit to asset book values. This example illustrates why Equitable supports a shorter time horizon for grading to occur (no more than 1 year).

The graph below shows the Barclay’s A-rated corporate bond spreads over the past 14 years. The chart demonstrates the swift mean reversion of spreads towards the 10-year moving average corporate spread following each peak. We quantified this pattern by looking at the time for spreads to revert 75% of the way back to the 10yr moving average following each peak in spreads and in each case found that 75% mean reversion occurred within 1 calendar year.

![Single A Corporate Bond Spreads](image)

**Aggregation of Reserves:**

The ARWG proposal allows aggregation of reserves if certain aggregation principles are met (i.e. aggregating policies that have similar risk management strategies, disallowing aggregation for policies that are administered or managed separately, etc.).

Equitable broadly supports the concept of aggregation in reserving, as the aggregation of risk is at the core of the insurance industry. The key risk of including aggregation within reserving is the risk that the projected profits on profitable contracts/product lines are not realized over time and therefore are not available to supplement reserves for in-the-money contracts/product lines. As such, the risk of aggregation equates to the risk that economic and policyholder behavior assumptions on profitable product lines are not realized.
Equitable believes the present governance over aggregation, principally through denying aggregation across major liability types, does not align with the ultimate concern about actuarial risk and is at best a crude guardrail. Equitable recommends a two-fold governance mechanism consisting of:

a) Governance over assumptions via mechanisms such as the Standard Projection Amount
b) Disclosure of total aggregation benefits utilized in VM-22 PBR report

Equitable believes this tandem is the best way to govern policyholder behavior risk because it (a) directly guardrails key assumptions for both positive reserve (“in-the-money”) and profitable/negative reserve (“out-of-the-money”) business and (b) alerts regulators to situations where company capital may not be sufficient to withstand material deviations from the failure to realize projected profits.

Conclusion:
Equitable appreciates the opportunity to comment on the ARWG’s VM-22 proposal and we look forward to working with the ARWG and regulators to develop an appropriate principle based reserving framework for fixed annuities. We are available to discuss our comments further as desired.

Sincerely,

Aaron Sarfatti, Chief Risk Officer
Stephen Tizzoni, Head of Actuarial Regulatory Affairs
Future Mortality Improvement Recommendation (VM20)

MORTALITY IMPROVEMENTS LIFE WORKING GROUP (MILWG) OF THE ACADEMY LIFE EXPERIENCE COMMITTEE AND SOA PREFERRED MORTALITY PROJECT OVERSIGHT GROUP (“JOINT COMMITTEE”)

NAIC Spring Meeting - April 8, 2021

Individual Life Insurance
Future Mortality Improvement for VM20 Products

GOAL: To allow a prudent level of future mortality improvement (FMI) for VM20 products beginning with the 2022 valuation manual

- FMI scale will be developed, updated and made available to practitioners annually
- Updates will be limited to a threshold of materiality for making a change
- Two versions of the scale will be published: Basic and Loaded
- Period of scale application: 20 years
Recommended FMI Scale Methodology:
Modification of Consistent Framework for MI Scale Development

**Historical Basis**
- Annual AG 38/VM 20 MI scale adopted annually
- Best estimate of recent historical MI

**Transition Period**
- Grade from historical basis to a long-term MI rate ("LTMIR") at 10 years
- MI will remain level to 15 years
- Grade to no improvement at 20 years
- Linear interpolation for grading

**Long-term MI rates ("LTMIR")**
- "LTMIR" defined as average of projection years 10-15 from SSA intermediate projection ("Alt 2")

**Recommendation: Consistent Framework Approach Simplified Method**

- **Valuation Date**
- **Transition Period**
- **Long-term MI rate (LTMIR)**
- **Transition Period**

LTMIR will vary by age only

Starting level: VM20/AG38 MI Rates

Vary by sex and age

MI = 0
Loading/Margin Considerations

- **MARGIN ON THE INCREMENTAL MORTALITY IMPROVEMENT SCALE**
  - Simplified method represents our “best estimate”
  - Margin will be included for all companies
    - Companies may use a more conservative MI but not less conservative
  - Margin will take the form of a flat % reduction in the best estimate MI scale
    - Current thinking is between one-quarter and one-third reduction in MI levels
  - There will be a discontinuity in the starting rates for FMI and those used up to the valuation date representing the application of the margin

- **OPTIONS DISCUSSED:**
  - Greater volatility in recent historical data and for certain age groups

Items for Discussion in Phase 2

- **SHORTER TERM ISSUES**
  - Consideration of COVID-19 impacts when we reach 2020 data inclusion
    - Shock
    - Potential longer term impacts
  - Impacts of opioid epidemic
  - Threshold of materiality for making a change in a given year
  - Socioeconomic differences (between general and insured population)

- **LONGER TERM ISSUES**
  - Consideration of cohort effects
Next Steps

- Amendment Proposal Form /methodology approval
- Implement smoothing process
- Finalize margin levels
- Develop best estimate and loaded scales for 2022 implementation

Contact Information

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Khloe Greenwood
Life Policy Analyst
American Academy of Actuaries
greenwood@actuary.org
Life Actuarial (A) Task Force
Amendment Proposal Form 2020-10
Exposed for a 45-day public comment period ending May 25, 2021

Request for Comment: During the exposure, commenters are specifically asked to address whether the “may” in 9.C.7.f, as well as 9.C.3.g, should be changed to “shall”. That is, rather than the SOA rates for historical and future mortality improvement being optional, they are required. However, if historical or future mortality improvement were overall positive and so not applying it would be conservative, then that would still be permissible as a simplification, since VM-20 Section 2.G would still apply here. Thus, the difference between “may” and “shall” would arise if historical or future mortality improvement were ever overall negative and so not applying it would be less conservative and so not permissible.

Please submit comments to Reggie Mazyck (RMazyck@naic.org) by COB 5/25/21.
Life Actuarial (A) Task Force/ Health Actuarial
(B) Task Force
Amendment Proposal Form

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


Reflect a prudent level of mortality improvement beyond the valuation date.

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


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

See attached Appendix.

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

The current Valuation Manual requirements are beyond moderately adverse with regard to future mortality improvement when significant future mortality improvement is expected. The requirements also need to be clarified for the handling of historical or anticipated future mortality deterioration (i.e., negative improvement). We propose to reflect a prudent level of mortality improvement beyond the valuation date, using SOA analysis for best estimate future mortality improvement and margin.

With the reflection of a prudent level of future mortality improvement in the mortality assumption, the interim 1/2cx approach to YRT is a reasonable consideration for a long-term approach.
Appendix

VM-20 Section 6.A.2.b.v:

v. Mortality improvement beyond the projection start date, other than that outlined in VM-20 Section 9.C.7.f, may not be reflected in the mortality assumption for the purpose of calculating the stochastic exclusion ratio.

VM-20 Section 8.C, introductory paragraph:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

VM-20 Section 8.C.18 and Guidance Note:

18.

When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

VM-20 Section 9.C.2.h:

h. Mortality improvement shall not be incorporated beyond the valuation date in the company experience mortality rates. However, historical mortality improvement from the central point of the underlying company experience data to the valuation date may be incorporated.

Guidance Note: Future mortality improvement is not applied to the company experience mortality rates since it would be duplicative of the future mortality improvement that is applied to the prudent estimate assumptions for mortality in Section 9.C.7.f.
VM-20 Section 9.C.3.g:

g. Mortality improvement shall not be incorporated beyond the valuation date in the industry basic table. However, historical mortality improvement from the date of the industry basic table (e.g., Jan. 1, 2008, for the 2008 VBT and July 1, 2015, for the 2015 VBT) to the valuation date may be incorporated using the improvement factors for the applicable industry basic table as determined by the SOA, adopted by LATF, and published on the SOA website, [https://www.soa.org/research/topics/indiv-val-exp-study-list/](https://www.soa.org/research/topics/indiv-val-exp-study-list/) (Mortality Improvement Rates for AG-38 for Year-End YYYY).

**Guidance Note:** Future mortality improvement is not applied to the industry basic table, since it would be duplicative of the future mortality improvement that is applied to the prudent estimate assumptions for mortality in Section 9.C.7.f.

To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the most recent set of prior mortality improvement rates adopted by LATF and published on the SOA website.

VM-20 Section 9.C.7.f (new section):

The prudent estimate assumptions for mortality may be adjusted to reflect up to 20 years of future mortality improvement that the company expects beyond the valuation date, using prudent future mortality improvement factors no greater than the loaded factors determined by the SOA, adopted by LATF, and published on the SOA website, at [link/reference to SOA site TBD].

**Guidance Note:** Mortality improvement may be positive or negative (i.e., deterioration).

To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the mortality improvement rates for the prior year (year YYYY-1).

VM-31 Section 3.D.3.i:

i. **Adjustments for Mortality Improvement** – Description of and rationale for any adjustments to the mortality assumptions for mortality improvement up to and beyond the valuation date. Such a description shall include the assumed start and end dates of the improvements and a table of the annual improvement percentage(s) used, both without and with margin, separately for company experience and the industry basic table(s), along with a sample calculation of the adjustment (e.g., for a male preferred nonsmoker age 45).

VM-31 Section 3.D.11.c.i:
If the company believes the method used to determine anticipated experience mortality assumptions includes an implicit margin, the company can adjust the anticipated experience assumptions to remove this implicit margin for this reporting purpose only. If any such adjustment is made, the company shall document the rationale and method used to determine the anticipated experience assumption.

**Deleted:** For example, to the extent the company expects mortality improvement after the valuation date, any such mortality improvement is an implicit margin and, therefore, is an acceptable adjustment to the anticipated experience assumptions.
Statement on Level of Documentation, Conning Intellectual Property:

The Task Force received several comment letters with respect to full documentation of the NAIC Economic Scenario Generator specifications, calibration and tools. For example, the American Academy of Actuaries Economic Scenario Generator Work Group in their comments stated that many key elements of full ESG documentation are missing, and that achieving full documentation is important to understanding whether the ESG is fit for use in principle-based reserve and capital calculations. In their comment letter the Academy referred to ASOP 56, which provides that “when selecting, reviewing or evaluating the model, the actuary should confirm that in the actuary’s professional judgment the model reasonably meets the intended purpose.” We will not be getting into an extended discussion of ASOP 56, but we note that the intended purpose for the NAIC ESG is to help set reserves and capital as “prescribed by applicable law”. LATF considered the issue of whether to permit insurers to use other proprietary ESGs in meeting their statutory reserve and capital requirements, and it was ultimately determined that we would continue with our current format of a prescribed ESG for use under the Valuation Manual. This will better produce uniform results that can be relied upon by states in regulating these companies. In essence, the prescribed ESG developed by the Academy and currently required under the Valuation Manual would be replaced by an ESG prescribed under law that we are developing with Conning.

In our opinion, Conning has been very forthcoming with various requests with respect to documentation, and we are continuing to work with Conning to develop documentation that would prove satisfactory to everyone. However, there is a limit under which we can expect Conning to supply documentation. Under the NAIC’s Professional Services Agreement with Conning, Inc., Conning retains ownership of its Intellectual Property, including its software and source codes. The Task Force understands that there is a limit to which Conning will share certain information, and that their ESG is proprietary. The NAIC remains committed to providing a prescribed ESG for our regulated companies that best reflects the potential future economic environments our companies could be exposed to, but we also want to respect the proprietary rights of our vendors. Monthly scenario files produced by the new ESG will remain free to use by the companies, and we are not adding increased regulatory costs. The Task Force remains fully committed to developing the best ESG for regulatory purposes, and we ask for everyone’s patience and reasonableness in helping us achieve this goal. The Task Force continues to believe that Conning is best situated to this task, which is why we retained them as our vendor.

Mike Boerner, ASA, MAAA
Chair of the Life Actuarial (A) Task Force (LATF)
NAIC ESG Comments: Common Themes

Pat Allison, FSA, MAAA – NAIC Managing Life Actuary
Scott O’Neal, FSA, MAAA – NAIC Life Examination Actuary
Dan Finn, FCAS, ASA – Managing Director at Conning

Agenda

1. Discuss Common Themes Present in the ESG Comment Letters Received by the NAIC
   a. Level of Negative Treasury Yields
   b. Corporate Model Complexity
   c. Extreme Equity Returns
   d. Inversion Frequencies
   e. Equity Model Link to Treasuries
   f. International Returns
   g. Timeline
   h. Data Format
   i. Projection Period
   j. Documentation
2. Open Discussion on Comments not Covered in Common Themes
Level of Negative Treasury Yields

**Commentary:**
- “The [initial] exposed scenario set, which is as of 12/31/19, has interest rates as low as -4.8%, which seems quite extreme. The likelihood and magnitude of negative interest rates produced by the model may be even more extreme when calibrated to more recent market conditions” - American Academy of Actuaries
- “…we believe that the projected frequency and severity of negative rates should be similar to historical US experience and not be unduly influenced by experience in other economies outside the US. Historically, no period of negative rates in the US has lasted for a meaningful period of time.” – ACLI
- “Equitable believes that the recent European experience with negative rates is a reasonable benchmark to establish a lower bound on negative rates.” - Equitable

**Response:**
- Regulators and Conning will develop targets to control the level of negative treasury yields
  - Likely target steady state distribution
  - May take several forms (e.g. x% below 0%, target skew)
  - Likely will NOT target short-term results: too heavily impacted by initial conditions
  - Likely will NOT target absolute minimum: too subject to sample variation

Corporate Model Complexity

**Commentary:**
- “Conceptually, we support the goals to have stochastic spreads, credit migration, granular credit modeling, and consistency between basic and robust data sets. However, we have several concerns:
  - We lack sufficient documentation on GEMS’ underlying credit model, assumptions, or existing calibration.
  - …discrepancies between prescribed general account credit assumptions … and … credit scenarios.
  - …tradeoff of a more sophisticated model …relative to the increased complexity…” - ACLI
- “Until we have complete documentation of the credit model, the ESGWG suggests revisiting whether a simpler approach to simulating bond fund returns (not requiring a credit model) would be more appropriate.” – American Academy of Actuaries

**Response:**
- **Regulator Decision:** Should the more complex current credit model be used, or a simpler model be developed?
  - Benefits of GEMS Corporate Model:
    - Better captures nature of these investments
    - Does not involve any additional build out
    - Links Basic and Robust Data Sets
  - Will require substantial additional documentation on this model – currently in development
Extreme Equity Returns

**Commentary:**
- “Equity returns appear to be explosive in the upside and downside tails.” – Prudential
- “Equity indices lose all value in some scenarios while increasing hundreds of times in others.” – American Academy of Actuaries
- “We would like a better understanding of jump process/parameters & comparison of returns after jumps vs. history (which includes strong market recovery in a relatively short time period after jump down). The S&P 500 (price index) has negative returns over 30 years in 12% of scenarios even though this has never been observed in history.” – ACLI

**Response:**
- **Regulator Decision:** Do regulators want to alter the targets for the mean and standard deviation of the Equity model to limit the extremity of the tail scenarios?
- Extreme returns are almost entirely driven by the expected mean and standard deviation of the annual returns for each index.

Inversion Frequencies

**Commentary:**
- “…inversions [in the 12/31/19 Revised Baseline] for short maturities are still relatively frequent (~25% of scenarios]…The frequency of short rate inversions also worsens dramatically in the first five years of the 12/31/2020 [Revised Baseline] scenarios.” – ACLI
- “While the revised scenarios are significantly improved vs. the original scenarios in this regard, the amount of yield curve inversions is still above what one would expect based on historical experience. Equitable encourages further discussion between industry and regulators on this topic.” – Equitable
- “Two features of these scenarios we consider troublesome are the magnitude of negative interest rates and the shape and frequency of yield curve inversion.” – Pedersen/Tenney

**Response:**
- Unlikely to specifically target inversion frequencies, however, the number of inversions will be reviewed in the scenario output for reasonableness.
- Inversion frequencies are tightly linked to the average term premium - which is being targeted.

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Average 20 Yr – 1 Yr</th>
<th>Inversion Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 Years</td>
<td>2.3%</td>
<td>1.25%</td>
</tr>
<tr>
<td>40 Years</td>
<td>2.0%</td>
<td>3.75%</td>
</tr>
<tr>
<td>60 Years</td>
<td>1.5%</td>
<td>13.19%</td>
</tr>
<tr>
<td>80 Years</td>
<td>1.4%</td>
<td>11.25%</td>
</tr>
</tbody>
</table>
Equity Model Link to Treasuries

**Commentary:**
- "We do not support the formulaic linkage ... given the lack of historical evidence." – ACLI
- "Equitable supports the structural linkage between interest rates and equity returns via an equity risk premium as utilized in the exposed GEMS scenarios... We would invite the consideration of expressing equity returns as a function of longer-term interest rates ... as that could help stabilize equity returns from calibration to calibration." – Equitable
- "The ESWG believes it is important to understand this connection that was not in the old model, and to consider the impact the connection has on reserve and capital levels and whether calibration standards may need adjustment in level and/or form as a result." – American Academy of Actuaries

**Response:**
- GEMS links expected equity return to current short Treasury Yield. The AIRG model does not have a link between these models
- **Regulator Decision:** Should there be a link between the Treasury and Equity models in the new ESG?

International Returns

**Commentary:**
- "The model returns should be calibrated similarly to the AIRG, with the addition of recent history. In particular, low EAFE returns and higher SPX/EAFE correlations may be contributing to inconsistencies in the risk return relationship between different equity indices." – ACLI
- "The exposed scenarios set international dividend yields to zero even though EAFE dividends have historically been non-zero." – Prudential
- "EAFE index returns meaningfully below US returns on a risk-adjusted basis" - Equitable

**Response:**
- **Regulator Decision:** Should International Diversified Equity returns align with history or risk/return framework?
- Exposed scenarios only have Total Return
  - Conning is developing a revised specification
  - Expect to release shortly
- For the past 30+ years, International Diversified Equity returns have underperformed
  - About 2% below Large Cap per year with slightly higher volatility
Timeline

Commentary:

- "The ESGWG believes the implementation timeline does not leave enough time for regulators and interested parties to:
  - (a) Review the totality of exposed documentation and adequately understand the newly proposed ESG...
  - (b) Discuss the properties that scenario sets used for reserves/capital should have...
  - Iterate to desirable field-testing options based on (a) and (b).
  - Conduct a field test, allowing time for additional/iterative testing..." - American Academy of Actuaries
- While ACLI recognizes the need to get a better generator in place as soon as possible, our observations to date do not give us comfort in the current state of the proposed model which may indicate timeline issues.” – ACLI

Response:

- The NAIC’s current plan is to continue with the existing timeline, however, adjustments will be made to the timeline if necessary to ensure regulators and interested parties can properly evaluate the new ESG.
Data Format

**Commentary:**
- “For use in companies’ existing models, the ESWG suggests publishing scenario sets in two alternative .CSV file formats: (A) GEMS .CSV file format, which is currently exposed, and (B) the Academy Interest Rate Generator (AIRG) multiple .CSV file format.” – American Academy of Actuaries
- “The prescribed generator must automatically output prescribed scenarios in a common electronic format.” – ACLI
- “…it may be helpful to have scenarios available in the current format, as suggested, but it is also helpful to the additional indices and data points available for the “full Conning format” – Link Richardson

**Response:**
- Conning can easily adjust this to meet industry’s needs
- Specifically looking for feedback on a single desired format – Questions Include:
  - All Yield Curve points or only selected?
  - Spot Rates and Coupon Curves?
  - Income and price or just total returns?
  - Incremental Returns or Wealth Factors?
  - One big file or separate files by column?
  - Months as rows or columns?
### Documentation

<table>
<thead>
<tr>
<th>Commentary:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• &quot;...full documentation of the model ... enables actuaries to adequately understand the dynamics of the model and objectively evaluate whether the scenario sets it produces are fit for purpose ... as required of actuaries by ASOP No. 56, Modeling, and ASOP No. 41, Actuarial Communications...&quot; - American Academy of Actuaries</td>
</tr>
<tr>
<td>• &quot;...we request more thorough and comprehensive documentation which will aid in understanding of the model and make the decisioning and testing process more efficient.&quot; - ACLI</td>
</tr>
<tr>
<td>• &quot;Regulators and interested parties must have sufficient information to discuss and understand the proposed interest rate, equity, credit spread / default models; any interrelationships / dependencies; and their calibration...&quot; - Prudential</td>
</tr>
<tr>
<td>• &quot;we respectfully submit that it [full documentation] should mean that sufficient details are provided so that a determined risk management professional is able to fully understand the model dynamics and be able to approximately reproduce the model output and calibration parameters ...&quot; - Pedersen/Tenney</td>
</tr>
<tr>
<td>• Continue expanding documentation: Recommend additional documentation as delineated in ACLI comment letter - Equitable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The NAIC and Conning are committed to releasing an appropriate level of documentation to facilitate an understanding of the new ESG while recognizing Conning’s intellectual property rights.</td>
</tr>
</tbody>
</table>
March 24, 2021

Mr. Mike Boerner  
Chair, Life Actuarial (A) Task Force (LATF)  
National Association of Insurance Commissioners (NAIC)  

Dear Mr. Boerner,  

The American Academy of Actuaries’ Economic Scenario Generator Work Group (the “ESGWG”) appreciates the opportunity to offer comments on LATF’s Economic Scenario Generator (ESG) exposures.

1. Proprietary ESGs  
As a general point, the ESGWG would like to reiterate the view previously communicated by Academy Life Practice Council work groups that the use of scenario sets generated by proprietary ESGs be permitted as an alternative option to scenario sets prescribed by the NAIC, subject to proper documentation on how the scenario sets were developed and why they are appropriate for statutory reserves and capital.

2. Full ESG Documentation  
Deliverable I of NAIC RFP #2053 is “Full documentation on the ESG specifications, calibration, and tools.” The ESGWG would like to reiterate the importance of this deliverable because it is full documentation of the model that enables actuaries to adequately understand the dynamics of the model and objectively evaluate whether the scenario sets it produces are fit for purpose (adequate for determining reserves and capital, irrespective of the starting yield curve) as required of actuaries by Actuarial Standard of Practice (ASOP) No. 56, Modeling, and ASOP No. 41, Actuarial Communications.

   a. ASOP No. 56, Modeling, provides guidance to actuaries when performing actuarial services with respect to using, reviewing, or evaluating models. Section 3.1.2 of ASOP No. 56 states actuaries “evaluating the model … should confirm that, in the actuary’s professional judgment, the model reasonably meets the intended purpose.” Section 3.1.3 of ASOP No. 56 states that “[w]hen using the model, the actuary should make reasonable efforts to confirm that the model structure, data, assumptions, governance and controls, and model testing and output validation are consistent with the intended purpose.”

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1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
b. Section 3.2 of ASOP No. 41, *Actuarial Communications*, states “In the actuarial report, the actuary should state the actuarial findings, and identify the methods, procedures, assumptions, and data used by the actuary with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary’s work as presented in the actuarial report.”

Although several pieces of ESG documentation have been exposed by LATF, the ESGWG believes that many key elements of full ESG documentation are missing. Furthermore the ESGWG believes that achieving full documentation relies on the critical project path of adequately understanding how the ESG will perform under different conditions and assessing whether scenario sets produced by the ESG are fit for use in principle-based reserve and capital calculations. The ESGWG also believes that a lack of sufficient documentation could unintentionally impact the ESG quantity and quality of these important risk management tools available to the life insurance industry. Additional detail can be found in *Exhibit 2.1—ESG Documentation*, but as a starting point, here are two specific pieces of documentation that, as yet, have not been publicly provided:

- The exact means by which the ESG model is adjusted to fit any discrepancies to the starting yield curve, and exactly how those discrepancies run off over the course of the projection (the entire yield curve, not just the three points corresponding to the model’s three state variables).
- The correlations between the various equity and bond funds.

3. Significant Differences From Previously Prescribed ESG

The ESGWG does not believe the newly proposed ESG needs to be substantially similar to the Academy’s Interest Rate Generator (AIRG). Indeed, the proposed ESG is not. But the ESGWG does believe it is important that regulators and interested parties appreciate just how different the two models are (in both underlying structure and calibration), generally agree that the differences are warranted, and understand the impact the differences will have on the scenario sets produced and the level and volatility of industry reserve and capital levels, including how model dynamics and interrelationships will change in the long term as the current economic environment changes. This will take time and additional documentation, but to start with, the ESGWG would like to highlight the following three significant differences:

a. **Lack of explicit MRP**—The old model has an explicit and intuitive mean-reversion parameter (MRP) that changes rather slowly according to a specified formula. The new model has no analogous MRP for regulators to explicitly set or control. Instead, NAIC’s vendor, Conning, has agreed to target an MRP by tweaking various parameters during calibration, but as seen in the revised baseline scenario set, this can have unintended consequences given the various linkages in the model. And it remains to be seen how sensitive mean reversion is to the current economic environment—e.g., to the observed yield curve on the valuation date. The ESGWG believes it is important to understand this significant change in the mean-reversion process and resulting impact on the volatility of capital over time.

b. **Connection Between Interest Rates and Equity Returns**—The old model has no such connection. The simple formulaic connection in the new model (equity risk premium over short Treasury rate) is largely based on actuarial judgment and the goal that the model produces risk-neutral scenarios. Empirical evidence suggests the equity risk premium depends on non-modeled macroeconomic factors (historical correlations have been both highly negative and highly

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2 This exhibit and subsequent exhibits cited are included in the enclosure to this comment letter.
positive). This has the potential to magnify the tails because calibration points in the new model depend on the starting yield curve in a way that they did not in the past. It also has the potential to make long-duration insurance liabilities dependent on overnight Treasury rates, which seems artificial and counterintuitive. The ESWG believes it is important to understand this connection that was not in the old model, and to consider the impact the connection has on reserve and capital levels and whether calibration standards may need adjustment in level and/or form as a result.

c. **Stochastic Modeling of Credit Spreads and Defaults for Bond Fund Returns**—The new ESG simulates bond fund returns by first using a credit model to simulate each of the individual bonds contained in the bond fund; e.g., using stochastic credit spreads, transitions, and defaults. The old ESG uses a simpler approach that does not involve a credit model. To date, the ESGWG simply does not have enough documentation on the new credit model to comment further on the impact this significant change may have and whether it is desirable or not. Until we have complete documentation of the credit model, the ESWG suggests revisiting whether a simpler approach to simulating bond fund returns (not requiring a credit model) would be more appropriate. Regulators may also wish to consider the degree to which the approach for simulating bond fund returns is consistent with the regulatory framework for modeling insurer general account assets, which requires using deterministic prescribed credit spreads and defaults and could easily lead to calibration inconsistencies.

4. **Implementation Timeline**

   The ESGWG believes the implementation timeline does not leave enough time for regulators and interested parties to:
   a. Review the totality of exposed documentation and adequately understand the newly proposed ESG model and the scenarios it would produce under various initial conditions.
   b. Discuss the properties that scenario sets used for reserves/capital should have and evaluate the new ESG and its scenario sets on that basis.
   c. Iterate to desirable field-testing options based on (a) and (b).
   d. Conduct a field test, allowing time for additional/iterative testing (given the likelihood there will be adjustments based on what is learned from prior iterations of testing).

   The ESGWG also believes that approval in November/December could present companies and vendors with an insufficient short timeframe to implement the final ESG in their systems.

5. **Scenario Sets – Rates**

   Although the ESGWG may have additional comments as additional missing documentation is exposed, the ESGWG’s initial comments on the baseline scenario set (exposed 12/18/20) can be found in Exhibit 5.1: Scenario Sets—Rates. Key issues include the following:
   a. The exposed scenario set, which is as of 12/31/19, has interest rates as low as -4.8%, which seems quite extreme. The likelihood and magnitude of negative interest rates produced by the model may be even more extreme when calibrated to more recent market conditions.
   b. A comparison of risk-neutral and real-world calibrations implies a negative market price of risk for long-term interest rates.
   c. Equity indices lose all value in some scenarios while increasing hundreds of times in others.
   d. Unreasonable short-end inversions. In nearly all scenarios, the yield curve is inverted between 1-month and 2-year rates (fixed in the revised baseline scenario set).

   The ESGWG also reviewed the revised baseline scenario set (exposed 2/24/21). Although the addition of a long-term overnight yield target appeared to fix (d) above, the other issues found in the
baseline scenario set are still present, even exacerbated for example, for (a) negative rates are even more extreme, and for (c) equity indices have even more extreme tails. This highlights how calibrating ESG models can be complicated; i.e., recalibrating to fix a particular issue can easily have unforeseen consequences, often exposing new issues or exacerbating existing issues. The ESGWG suggests discussing the properties that scenario sets used for reserves/capital should have, and understanding the degree to which desired scenario set properties can be achieved via recalibration of real-world (RW) and/or risk-neutral (RN) parameters. It may be that certain desired scenario set properties are out of reach given constraints on calibration and/or model structure.

6. Scenario Sets—Accompanying Report
   To facilitate reviewing newly published scenario set files, the ESGWG suggests adding: (A) a new section on Model Input, and (B) additional statistics and charts for the existing section on Model Output. Additional detail can be found in Exhibit 6.1: Scenario Sets—Accompanying Report.

7. Scenario Sets—File Format
   For use in companies’ existing models, the ESGWG suggests publishing scenario sets in two alternative .CSV file formats: (A) GEMS .CSV file format, which is currently exposed, and (B) the Academy Interest Rate Generator (AIRG) multiple .CSV file format. Additional detail can be found in Exhibit 7.1: Scenario Sets—File Format.

We look forward to further documentation and discussion on the NAIC’s ESG project.

Sincerely,

Jason Kehrberg, MAAA, FSA
Chairperson, Economic Scenarios Work Group
American Academy of Actuaries

Enclosures: Exhibits 2.1, 5.1, 6.1 and 7.1
Exhibit 2.1 – ESG Documentation

There is widespread expectation that the NAIC will be providing sufficient details on the new models so that interested practitioners can attain a complete operational understanding of all aspects of the simulation of model output, calibration of the models, and application of related tools. This expectation was set by the requirement in item I in the Deliverables section of the RFP which states: “[f]ull documentation on the ESG specifications, calibration, and tools.” The requirement of full documentation was reiterated on slide 11 of the October 27, 2020 NAIC presentation of Pat Allison “ESG Implementation Project: Background and Deliverables” which states: “Conning will provide full documentation on specifications, calibration, and tools. This will include: Full documentation of the necessary components used to develop the Basic Data Set.” This is an important commitment since it is the Basic Data Set which is to be prescribed by the NAIC for statutory reporting.

As summarized on slide 7 of the aforementioned October 27, 2020 NAIC presentation, the components of the Basic Data Set are:

- Treasury Yields - 1M, 3M, 6M, 1Y - 30Y by year; Spot and Coupon Yields.

As of the end of February 2021, the NAIC has provided three documents that relate to the models underlying the Basic Data Set:

- NAIC Scenario Set Technical Documentation - Interest Rates Model
- NAIC Scenario Set Technical Documentation - Equity and Dividend Model
- NAIC Scenario Set Technical Documentation - Corporate Yield Model

No specific documentation has been provided on how the bond returns are computed. The NAIC Scenario Set Technical Documentation - Interest Rates Model contains significant information on the treasury interest rate model but does not constitute full documentation. The NAIC Scenario Set Technical Documentation - Equity and Dividend Model provides a sense of how the equity model works but is missing fundamental information. The NAIC Scenario Set Technical Documentation - Corporate Yield Model provides no meaningful details on how the corporate yield model works.

Full documentation must achieve the following outcomes for each of the models used to develop the Basic Data Set.

1. Full specification of model dynamics.
2. Operational description of the calibration process.
3. Mapping of the calibration parameters into the model dynamics.

Full documentation of calibration requires the details of how the parameters for each model are determined and what data is used in the calibration procedure. It is reasonable to expect that someone who has understood the model specification and calibration documents would be able to arrive at similar model parameters. Indeed, the ability to independently reproduce calibration results is an important check and robustness and stability of a model.

Full specification of Treasury model dynamics requires the following:

1. Bond pricing formulas
2. State variable simulation procedure
3. State variable initialization procedure
4. Initial yield curve fitting procedure
5. Explicit mapping between real world and risk neutral model parameters
6. Documentation should use the original standard notation of Cox, Ingersoll, and Ross

Full specification of Equity model dynamics requires the following:
1. Dynamic specification for equity price return
2. Details of jump process for equity index
3. Correlation specifications for diffusion and jump terms across equity indices
4. Dynamic specification for dividend yield process
5. Any adjustments that need to be made to dividend process when very large jumps occur in the equity process
6. Specific linkages between equity returns and interest rates

Full specification of Bond Fund Return model dynamics:
The bond fund returns models appear to be based on a corporate bond pricing model called the corporate yield model. Therefore, to understand the bond fund returns the details of the corporate yield model are needed, including details on credit spreads, credit migration, loss given default and the relationships between rates/spreads and equity/credit. Similar information detail to what is needed for the treasury model is required. NAIC documents and presentations have indicated that the bond fund returns are based on an index of individual bonds. Therefore, the methodology/rules of the index construction are required.
Exhibit 5.1: Scenario Sets – Rates

Selected ESWG findings on rates baseline scenario set (exposed on 12/18/20):

A. Interest Rate Model
   1. Conning’s interest rate model structure and calibration (i.e., 1M to 2Y) are inverted in most scenarios nearly immediately and in nearly all scenarios after projection year 5.
   2. The frequency and severity of negative interest rates in the exposed scenario set are high
      a. Rates for short-term maturities approach -5%.
      b. Roughly 20% of the 1Y and 2Y yields are negative between projection years 5 and 15, and those rates are negative in more than 15% scenarios over the longer term.
   3. Insufficiently broad range of rates or other anomalies / inconsistencies
      a. 20Y yields were above 8% for much of the period between 1974 and 1990, but exposed 20Y yields are above 8% less than 1% of the time.
      b. While there are more low-rate scenarios than the AIRG, 20Y rates seldom average below 1% over the 30-year projection (and never average below 70-80 bps).
      c. In the exposed scenarios, annualized realized volatility for 20Y yields is nearly double the annualized realized volatility for 1Y yields. This is inconsistent with both Conning’s 1995+ historical period (where 1Y volatility was lower than 20Y) and LATF’s 1953+ historical period (where 1Y volatility was higher than 20Y by ~50%, not double). The relationship between the volatilities for longer and shorter maturities may be contributing to shorter term bond funds having higher volatility and lower returns over the long term.

B. Equity Model
   1. Index returns explode in both tails. In some scenarios equity indices essentially become worthless while other scenarios have indices hundreds of times starting levels by year 30.
   2. Other characteristics of the equity distribution also seem to diverge from historical data
      a. Monthly S&P 500 returns in LATF’s exposure have substantially more negative skew and higher kurtosis than history.
      b. The S&P 500 (price index) has negative returns over 30 years in more than 5% scenarios (even though that has never been observed in history).
      c. The exposed scenarios set international dividend yields to zero even though EAFE dividends have historically been non-zero.
      d. SPX / EAFE correlations seem higher than long-term historical data.

C. Corporate Model:
   1. Credit spreads inferred by taking the difference between annualized corporate and government bond fund income returns suggest that
      a. LATF’s / Conning’s proposed long-term credit spread for bonds in the separate account are lower than the prescribed NAIC general account bond fund spreads.
      b. Extreme credit events in the scenarios appear to be materially higher than historical stresses.
   2. Month 1 income returns for government bonds do not seem to align with time 0 government bond yields. (Month 1 Short Gov income return ~ 1Y UST yield. Expected to align with the 50% 1Y / 50% 5Y given the short-term fund definition.)
**Exhibit 6.1: Scenario Sets – Accompanying Report**

To facilitate reviewing newly published scenario set files, the ESWG suggests adding the following to the report accompanying scenario sets.

**A. A new section on Model Input**
1. Values of the model parameters used to generate the associated scenario set
2. Starting state variables used to generate the associated scenario set

**B. Additional statistics and charts for the existing section on Model Output**
- Unless otherwise specified
  - Selected key rate tenors: 1M, 3M, 6M, 1Y, 2Y, 3Y, 5Y, 7Y, 10Y, 20Y, 30Y
  - Selected funds: all equity and bond funds included in the published scenarios
  - Selected time points: 0.25, 0.5, 1, 2, 3, 4, 5, 10, 20, 30, 40 and 50 years
  - Selected percentiles: 1, 2.5, 5, 10, 25, 50, 75, 90, 95, 97.5 and 99
  - Selected key rate pairs: 1m2s (2Y rate less 1M rate), 3m10s, 2s10s, 10s30s, 1s20s
  - Selected corp bonds: 1Y A, 5Y A, 10Y A, 30Y A, 1Y BBB, 5Y BBB, 10Y BBB and 30Y BBB
  - Selected yield curve shapes: Normal, Flat, Steep, Inverted, Humped (criteria TBD)

1. Not scenario path dependent
   - **a. Distribution of Key Rate Pair Term Spreads**
     - Key rate term spread (y-axis) by selected time points (x-axis)
     - One chart for each selected key rate pair
     - Legend: mean, min, max, selected percentiles

   - **b. Table on Key Rate Pair Inversions (no chart)**

<table>
<thead>
<tr>
<th>End of proj. mo.</th>
<th>Key Rate Pairs Term Spreads – Percent of Scenarios Where Negative</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1m2s</td>
</tr>
<tr>
<td>0</td>
<td>%</td>
</tr>
<tr>
<td>1</td>
<td>%</td>
</tr>
<tr>
<td>2</td>
<td>%</td>
</tr>
<tr>
<td>360</td>
<td>%</td>
</tr>
</tbody>
</table>

   - **c. Median Key Rate Yield Curves**
     - Key rate (y-axis) by key rate tenor (x-axis)
     - One chart showing median key rate yield curves
     - Legend: selected time points

   - **d. Table on Negative Key Rates (no chart)**

<table>
<thead>
<tr>
<th>End of proj. mo.</th>
<th>Key Rates – Percent of Scenarios Where Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1M</td>
</tr>
<tr>
<td>0</td>
<td>%</td>
</tr>
<tr>
<td>1</td>
<td>%</td>
</tr>
<tr>
<td>2</td>
<td>%</td>
</tr>
<tr>
<td>360</td>
<td>%</td>
</tr>
</tbody>
</table>
e. Distribution of Credit Spreads
   - Credit spread (y-axis) by selected time points (x-axis)
   - Charts: one for each selected corporate bond maturity and credit quality
   - Legend: mean, min, max, percentiles
f. Distribution of Default Losses (net of recoveries)
   - Default loss (y-axis) by selected time points (x-axis)
   - Charts: one for each selected corporate bond maturity and credit quality
   - Legend: mean, min, max, percentiles
g. Correlation Tables: (for each selected time point)
   - Table of correlations between selected tenors (change in key rates), selected funds (total returns), selected corp bonds (credit spreads), selected corporate bonds (default losses),
   - Table of correlations between a modeled key rate or total fund return and its volatility
   - Table of correlations between 10Y key rate and 2s10s term spreads
   - Table of correlations between 10Y key rate and 10s30s term spreads
h. Tables on Frequency of Yield Curve Shapes (TBD) and Transitions Between Shapes
   - Frequencies: At selected time points, over successive 10-year periods, and in total
   - Specific metric TBD
i. Table on speed of reversion to equilibrium/ultimate state
   - Specific metric TBD
j. Table on low interest rate persistency (“low for long”)
   - Specific metric TBD
2. Scenario path dependent
   a. Distribution of Cumulative Arithmetic Averages of Key Rates and Total Fund Returns
      - Cumulative arithmetic average (y-axis) by selected time points (x-axis)
      - One chart for each key rate tenor and fund
      - Legend: mean, min, max, selected percentiles
   b. Distribution of Cumulative Geometric Averages of Key Rates and Total Fund Returns
      - Cumulative geometric average (y-axis) by selected time points (x-axis)
      - One chart for each key rate tenor and fund
      - Legend: mean, min, max, selected percentiles
c. Distribution of Volatilities of Key Rates and Total Fund Returns
   - Volatility along each scenario path from time 0 to time t (y-axis) by time points (x-axis)
   - One chart for each key rate tenor and fund
   - Legend: mean, min, max, selected percentiles
d. Distribution of Cumulative Accumulation Factors of Key Rates and Fund Returns
   - Cumulative accumulation factor (y-axis) by selected time points (x-axis)
   - One chart for each key rate tenor
   - Four charts for each fund
      i. Total return
      ii. Price return
      iii. Dividend return
      iv. Excess return
         - Equity funds: Relative to the short Treasury rate
         - Bond funds: Relative to the Treasuries used to model the underlying bonds
   - Legend: mean, min, max, selected percentiles
e. Cumulative Risk/Return Profiles
   o Mean cum volatility (y-axis) by mean cum geometric average total return (x-axis)
   o Charts: one for each selected time point
   o Legend: selected funds
Exhibit 7.1: Scenario Sets – File Format

For use in companies’ existing models, the ESWG suggests publishing scenario sets in two alternative .CSV file formats:

A. GEMS .CSV file format, which is currently exposed, but with the following additional fields:
   1. Interest Rates – The values of the three state variables and their associated random numbers
   2. Equity and Bond Fund Returns – The random deviates for the Wiener process and jumps.

B. AIRG multiple .CSV file format:
   1. Interest Rates – One file with spot (annual effective) rates, one file with coupon (BEY) rates, each with the following 12 columns: Scenario, Time, 0.25y, 0.5y, 1y, 2y, 3y, 5y, 7y, 10y, 20y, 30y. The ESWG feels that these 10 points on the yield curve, appropriately interpolated, are adequate when doing projections for principle-based reserve and capital calculations.
   2. Equity and Bond Fund Returns – One file for each fund modeled by the ESG, with Time across the columns, Scenarios down the rows, and data showing total return only (not split by price and income).

"The ESWG also notes the current AIRG can produce scenario sets with projection lengths up to 100 years to support insurance products with very long durations, e.g., SPIAs and some life insurance products. Therefore, for the files specified in both A and B above, actuaries will need similarly long projection lengths out of the new ESG."
Brian Bayerle  
Senior Actuary  
March 24, 2021  

Mr. Mike Boerner  
Chair, NAIC Life Actuarial (A) Task Force (LATF)  

Mr. Philip Barlow  
Chair, NAIC Life-Risk Based Capital (E) Working Group  

Re: ACLI Comments on Economic Scenario Generator Exposure  

Dear Messrs. Boerner and Barlow:

The American Council of Life Insurers (ACLI) appreciates the opportunity to provide comments on the exposures related to the economic scenario generator (ESG) project. ACLI is committed to working with regulators on the modifications and implementation of Conning’s GEMS as the replacement for the current Academy Interest Rate Generator (AIRG). We acknowledge that the current generator has clear shortcomings and further acknowledge the need to get an improved generator in place as soon as possible.

That said, our initial analysis of the scenario set has surfaced anomalies and scenario results that we consider inappropriate. These anomalies include significant and sustained negative interest rates, a large number of yield curve inversions, extreme equity returns, and low Sharpe ratios for certain equity indices, none of which is consistent with historical experience. The underlying causes of these issues are not currently clear due to the absence of detailed documentation and may be deeply rooted in the model. For this reason, we request more thorough and comprehensive documentation which will aid in understanding of the model and make the decisioning and testing process more efficient. While ACLI recognizes the need to get a better generator in place as soon as possible, our observations to date do not give us comfort in the current state of the proposed model which may indicate timeline issues. We believe that the implications of the collective set of decisions must be understood in order to avoid potential unintended consequences (i.e., addressing one concern but creating another). We support a timeline that ensures that the new generator is fit for purpose.

Our letter is organized as follows:

I. Overarching Comments
   A. Anomalies in Scenarios
B. Needed Additional Documentation
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I. **Overarching Comments**

The Conning model represents a structural change relative to the current model, with interrelationships that should be vetted and understood. The components of GEMS (i.e., interest rate, equity, and corporate models) are linked, and their calibration (e.g., interest rate mean reversion level, volatility, and shift; equity risk premiums; jump parameters) should be evaluated holistically because a decision on one parameter or scenario property may have direct and indirect effects on scenario dynamics for multiple risk factors (e.g., changes to interest rate parameters will affect equity returns) both at a point in time and between reporting periods. In addition, the ESG has a complex relationship to the statutory requirements.

We believe that appropriate vetting and discussion of the key decision points is necessary so that regulators and industry can achieve the goal that the generator is fit for purpose in calculating reserves and capital. The discussion should go beyond individual technical decision points that, in a vacuum, may be reasonable but lead to an unreasonable scenario set. There should be a discussion of stylized facts and expectations around the results and their consistency with the relevant historical period. While the definition of the appropriate historical period can and should be debated, the results produced by the generator should be reasonable through the lens of that historical experience. As a reference to help assist in this discussion, Appendix One of our document outlines desirable attributes for the generator, which are further reflected in our specific comments on the exposures.

The focus of our following comments is the 12/31/2019 revised baseline scenario set and includes preliminary observations on the 12/31/2020 scenario set.

A. **Anomalies in Scenarios**

ACLI believes that the scenario generator should create a scenario set that reasonably reflects history, with some allowance for more extreme environments. Our initial analysis of the 12/31/2019 scenario set, however, has revealed several significant concerns. These concerns still appear to be present in the 12/31/2020 scenario set and may be generally exacerbated by lower initial interest rates.
Negative Rates: The revised 12/31/19 scenario set is generating significant and sustained negative interest rates. Short-term yields fall as low as -6.2%. Yields for maturities shorter than 1Y are negative during roughly 20% to 25% of the scenarios in projection years 5-15. Those yields are negative in ~15% to 20% of scenarios in the long term as illustrated in the following graph:

The frequency of negative rates is even more extreme (e.g., over 45% of scenarios have negative short-term yields in the first year) in the 12/31/2020 scenarios.

We believe that the projected frequency and severity of negative rates should be more consistent with historical US experience. Historically, no period of negative rates has lasted for a meaningful period of time in the US.

Yield Curve Inversions/Realized Volatilities: We are concerned by the number of inversions occurring within the scenarios. Based on our initial analysis of the revised 12/31/19 scenario set, the frequency of yield curve inversions appears elevated vs. history. While the revised baseline calibration addressed the 100% rate inversion problem in the initial set, inversions for short maturities are still relatively frequent (~25% of scenarios) as shown below:
The frequency of short rate inversions also worsens dramatically in the first five years of the 12/31/2020 scenarios.

In addition, realized volatilities for short maturities (e.g., 1-year rates) are roughly double the realized volatilities for long maturities (20-year rates). This is inconsistent with the historical data set used in Conning’s calibration and may also be contributing to other concerns with the scenario distribution we have observed (e.g., the ability to produce interest rate dynamics in recent history as well as the 1970s / 1980s, unintuitive long-term risk/reward relationships between bond funds).

We believe the yield inversions and realized volatilities should be more consistent with observable historical data.

**Extreme Equity Returns:** We have observed, as shown below, unusual distribution characteristics and jumps in the initial scenario set, the cause of which is unclear. At the extremes, there are scenarios that assume that equity indices essentially become worthless (see chart below for an example). The original baseline also includes indices that are 1000+ times (>100,000%) higher by year 30. We would like a better understanding of jump process / parameters & comparison of returns after jumps vs. history (which includes strong market recovery in a relatively short time period after jump down). The S&P 500 (price index) has negative returns over 30 years in 12% of scenarios even though this has never been observed in history. In the over 90 years of S&P 500 (SPX) data since 1928, monthly losses larger than...
25% and 20% have only occurred once (Great Depression) and 3 times (1929, 1932, 2008), respectively. Monthly declines of more than 25% occur in over 14% of Conning’s 30-year scenarios.
Mean Equity Returns / Return Relationships: Conning’s recommended calibration has a significantly lower view of long-term equity returns relative both to history and the AIRG. The model returns should be calibrated similarly to the AIRG, with the addition of recent history. In particular, low EAFE returns and higher SPX/EAFE correlations may be contributing to inconsistencies in the risk return relationship between different equity indices. We observe that the average Sharpe Ratio over 30 years for EAFE is ~18% vs. ~33% for S&P 500 in revised baseline scenario set as of 12/31/2019.

B. Needed Additional Documentation

Additional documentation will help enable industry to provide more constructive insights for a higher quality generator and a more efficient process. There are gaps in the interest rate model documentation (e.g., determination of the state variables), with more significant gaps noted in the equity model documentation (e.g., EAFE model, distribution, and correlation of jump processes) and the corporate / credit model. We note that the corporate model drives bond fund returns in the Basic Data Set, so while companies may not need the granular credit output in the Robust Data Set on an ongoing basis, the information is needed to appropriately vet the Basic Data Set.

We request the following additional documentation to assist in our review, noting while some of this may have been included in the March 18th exposures, the materials do not appear to substantively address the issues outlined below:

- Explanations of model selection considerations and theoretical justification for model choices (e.g., 3-factor vs. 2-factor model, formulaic equity risk premium relationship) as
these decisions determine fundamental scenario properties and their suitability for purpose.

- Direct and indirect relationships (e.g., equity risk premium, equity/credit, rate/spread relationships), including formulas, correlations, and any relationships imposed via judgment
- Methodology and formulas used to determine fund returns, including the composition of bond indices and derivation of bond fund returns, use / modeling of exchange rates in international equity returns
- State process information, including all distributions and correlations
- Calibration information, including model parameters and calibration targets at multiple points in time, methodologies for setting initial values and long-term targets, how and where historical data is used and the benchmarks used, the process and judgment used when a calibration fails, and identification of the values that would be updated at each reporting period, regularly, or based only on triggering events
- The criteria for evaluating the reasonability of each published scenario distribution (beyond validating that targets are reproduced)

In addition to documentation for Conning’s model and calibration, LATF should develop and document target scenario properties or stylized facts which can be done on a parallel track as documentation becomes available. Targets such as the original C-3 Phase 2 equity calibration points may be useful. It is important to confirm that the Conning generator and calibration can meet those targets under an appropriate range of market conditions and other sensitivities.

C. Timeframe Considerations

We encourage the Task Force to regularly assess the status of the timeline in light of the many steps to be completed prior to implementation. ACLI suggests the following considerations for additional milestones or adjustments for the expected timeframe of existing milestones:

- Additional time may be necessary to understand and confirm the suitability of the model and its calibration. Considerations include availability of documentation and adequate time to understand it, deliberation of key calibration decisions, adequate time to test impacts of changes, sensitivity testing and forecasting, and implementation to valuation systems and other processes. Additionally, smaller companies could be put at a disadvantage due to fewer resources to test and implement the change.
- Additional education sessions for regulators and interested parties may be necessary once more documentation is available to thoroughly understand the generator.
- The field testing start date may already be coming under pressure due to the lack of adequate documentation. There is currently no viable candidate for field testing as there are significant concerns with the revised baseline as noted in ‘Anomalies in Scenarios’.
- The timeline should provide time for consideration of reassessing generator modification(s) and parameters after the assessment of the field study results.
- Consideration in the implementation timeline should also contemplate time for companies to evaluate the potential impact of the new ESG on statutory reporting, risk management & hedging (due to changes in economic sensitivities), and system implementation.
We encourage the regulators to regularly assess the status of the timeline since failure to meet current and suggested milestones may adversely impact the timeline.

II. **Comments on Treasury, Corporate, and Equity ESG Goals and Proposed Recommendations**

ACLI agrees with many of the stated goals for the generator and notes the importance of a holistic view of how these come together for a generator that is deemed to be fit for purpose. This holistic view of the exposed scenario sets (which are based on "mixing and matching" of the Conning Standard Calibration parameters with the selected adjustments and overrides presented in the list of "ESG Goals") gives us some concerns about the viability of these recommendations and may require a fundamental or first principles recalibration of Conning’s model or selected model refinements to resolve these concerns. We have broken down our comments into three categories: areas of support, areas for improvement with additional dialogue or documentation, and areas of significant concerns:

A. **Areas of Support**

**Treasury goal #1 (Initial Yield Curve):** We support the goal that the model’s starting yield curve should match the actual starting yield curve as closely as possible. Our initial analysis suggests that the model would have had difficulty fitting historical rate curves. Based on our analysis to date, adjustments to the model beyond the grading period recommendation may be needed to fulfill this objective.

**Treasury goal #4 (Range of Results):** We support the goal that the model should be capable of producing a reasonable range of results for very long simulations. Based on our analysis to date, adjustments to the recommendation may be needed to fulfill this objective.

**Treasury goal #5 (Sustained Low Rates):** We support the goal that the ESG should be capable of producing low interest rates for an extended period of time. The definition of “low for long” should be based on plausible expectations and should be considered in conjunction with the broader scenario distribution. We observe that lowering the mean reversion point alone is not sufficient to achieve this goal. The structure of the mean reversion point, the mean reversion speed or strength, and volatility need to come into play so that scenarios have the appropriate degree of dispersion.

Regarding the speed of mean reversion, we observe that the exposed scenarios do not appear to be consistent with the recommendation of alignment with the current Academy scenarios. The GEMS scenarios (both original and Revised Baseline exposures) have significantly slower median reversion than the current Academy scenarios (as observed in the following chart). This difference may reflect structural differences between GEMS and the AIRG. Starting from 12/31/2019 initial conditions, median long-term rates in the Conning generator are 40 basis points below the corresponding AIRG median after 30 years. When mean yields do not approach their target within a typical projection period, it effectively results in an inadvertently lower target in today’s low-rate environment. Additionally, mean long-term yields decrease for...
the first several months in the Conning generator. It is unclear if this is intended or an unintentional side effect of the model calibration.

**Equity and corporate goal #1 (Returns are Representative):** We support the goal that returns should be provided for the types of funds representative of those offered in U.S. insurance products.

**B. Areas for Additional Dialogue/Documentation**

**Treasury goal #2 (Variety of Curve Shapes—also see above):** We support the goal that the model should produce a variety of yield curve shapes, and they should change over time. We recommend additional review of the appropriateness of yield curve shapes and the acceptable frequency of specific shapes (e.g., frequency of yield curve inversions, consideration of limitation of time for inverted curves).

**Treasury goal #6 (Sustained Volatility):** We support the goal that the model should produce interest rate levels that fluctuate significantly over long periods. Currently, we do not yet support the recommendation to use the GEMS volatility estimate. The volatilities from the initial scenario
set do not look to be related to the relevant historical period and are not explained by the available documentation. The volatilities may also be a source of the anomalies described above.

**Treasury goal #8 (Historical Data Period):** We support the goal that the ESG should be calibrated using an appropriate historical period. We would support consistency with the Academy generator’s historical period (starting in the 1950s), extended to include the most recent available data. Critical to this goal, the historical period should be consistently applied across the underlying calibration of state variables. Since Conning has effectively locked in significant aspects of their 1995+ based standard calibration (e.g., risk-neutral parameters, volatilities), it is unclear where they have reflected the data since 1953 in their calibration (other than when superimposing the mean reversion target). Using interest rate volatilities based on data since 1995 (generally a lower rate and lower volatility period) may lead to an insufficiently broad range of rates, which may not sufficiently capture disintermediation risk (from high-rate scenarios), and lead to other anomalies / inconsistencies.

**Equity and Corporate Goals #2 (Calibrated to Historical Period):** We support the goal that the ESG should be calibrated using an appropriate historical period. From the available documentation, it is not clear what historical period is currently being used by Conning. Consistent with Treasury goal #8, we believe the Academy generator’s historical period extended to include more recent data would be an appropriate period. Further, the scenarios that are generated by the model should be reasonable compared to the historical period results. The examples illustrated previously suggest areas where the revised baseline scenarios may be unreasonable (such as severely negative cumulative returns).

**Equity and Corporate Goals #3 (Stochastic Volatility):** We do not oppose the goal that the equity model should have stochastic volatility and that the initial volatility should be updated periodically. However, realized equity volatility appears to be higher in the Conning scenarios than in the Academy scenarios, and we do not have sufficient documentation to opine on the underlying rationale for this observed higher volatility. Stochastic volatility, if it exists, needs to decline over time to avoid arbitrage within the scenario sets. While we believe that there should be a defined process for updating initial volatility, the frequency and basis for the updates will need to be considered in conjunction with Conning’s jump process since the linkage between volatility and the jump process may increase the risk of procyclicality (e.g., higher likelihood of market stresses after a recent drop).

**Equity and Corporate Goals #6 (Higher Correlation in Tail):** We believe correlations between equity indices in stressed markets should be consistent with relevant historical data. We do not have sufficient documentation to opine on whether Conning’s approach is reasonable. Given the complexity of Conning’s model, we would like to understand Conning’s theoretical approach rather than focus on the results from any given scenario set.

**Equity and Corporate Goals #8-11 (Model for Returns, Separate Yield Curves by Rating, Stochastic Spreads, Dynamic Bond Credit Transitions):** Conceptually, we support the goals to have stochastic spreads, credit migration, granular credit modeling, and consistency between basic and robust data sets. However, we have several concerns:
1. We lack sufficient documentation on GEMS' underlying credit model, assumptions, or existing calibration.
2. We would like to understand the basis and consequences of discrepancies between prescribed general account credit assumptions and Conning’s assumptions and resulting credit scenarios.
3. It is unclear whether the tradeoff of a more sophisticated model is worthwhile relative to the increased complexity and lack of transparency (i.e., a significant amount of critical information only available in the Robust Data Set).

C. Areas of Significant Concern

Treasury goal #3 (Negative Rates—also see above): We do not inherently oppose the concept of negative interest rates. That said, we believe that the projected frequency and severity of negative rates should be similar to historical US experience and not be unduly influenced by experience in other economies outside the US. Historically, no period of negative rates in the US has lasted for a meaningful period of time. Negative rates are influenced by many model parameters, and each may entail different, potentially undesirable tradeoffs. In addition, the use of arbitrage-free scenarios may be contributing to the disconnect between the model and historical experience. While arbitrage-free scenarios are desirable (Treasury goal #7), a compromise may be preferable if necessary to prevent unrealistic scenario properties.

Equity and Corporate Goals #7 (Link between Equity and Treasury): We do not support the formulaic linkage between equity returns and Treasury yields given the lack of historical evidence. The existing approach in the AIRG allows for varying levels of correlation between rates and equities. At the same time, the correlations in the AIRG average close to zero across the entire distribution and have a historical basis. The selection of a strict formulaic relationship between equity returns and Treasury yields in every period appears to be driven by operational considerations (i.e., ability to simultaneously generate risk-neutral scenarios) unrelated to the NAIC’s objective, fundamentally changes the nature of the scenarios, and is not supported by historical data. Intuitively, this relationship has not held in every period due to other macroeconomic factors. If it did, the late 70s and early 80s would have had high returns for equities, and the current low interest rate environment would have poor returns. Equity risk premium relationships have varied significantly over time in a manner that is unlikely to be well represented by the current recommendation.
The proposed relationship is also likely to be a source of non-economic volatility. Reserves and capital will be sensitive to changes in overnight interest rates even though the underlying insurance liabilities generally would not be. This relationship may create an incentive to hedge against changes to the overnight rate due to the artificial dependency in the ESG. We note how Conning’s adjustment to target overnight rates in the revised baseline reduced equity returns by roughly 40% by year 30. Changes in actual overnight rates would also affect equity return paths in a manner that is unlikely to be offset by changes in other scenario parameters. For example, in the 2020 scenario set, equity index levels were approximately 10% lower at year 30 relative to the 2019 scenario set due to the lower initial overnight rates. However, the relationship varies at different periods, so any attempt to compensate for the change via high level adjustments to the equity risk premium would under/overcorrect depending on the product, introducing unintuitive results and volatility.

The revised baseline changes also illustrate how the explicit linkage may force unnecessary compromises between rate and equity distributions. The change to address a rate shortcoming in the original 12/31/19 baseline scenarios appears to have created or exacerbated inappropriate equity return distributions. Overall, we suggest an approach closer to the one used by the existing AIRG.

**Equity and Corporate Goals #4 (Model Jumps):** We do not oppose the goal of the ESG having the ability to generate very large losses and gains in short periods of time (i.e., jumps), but we have potential concerns about the recommendation to use Conning’s existing calibration given the extreme results observed in the upside and downside tails previously noted and so cannot yet support this recommendation. Additional information will help us assess the appropriateness of the existing calibration.

**Equity and Corporate Goals #5 (Long Recoveries):** While we do not oppose the goal of having some equity scenarios reflect the possibility of a very long recovery after a period of losses, we have observed that a large portion of 30-year returns for indices in the revised baseline scenario set seemed highly adverse (see comments on extreme equity returns above). Additional
documentation may help us understand the drivers of these outcomes. We believe that recovery scenarios should be calibrated to appropriate history.

III. Comments on ESG Scenario Statistics and Reports

We suggest that the generator produce the following additional statistics. Note that we may request additional statistics once we have sufficient documentation to better understand the GEMS model.

- Additional percentiles, particularly in the tail in the fan charts (or supporting data tables)
- Period-over-period (i.e., between reporting date) comparisons in the fan charts
- A distribution (fan chart) of cumulative average interest rate paths
- A distribution (fan chart) of total and price return accumulation factors for all equity and bond funds
- A distribution (fan chart) of credit spreads and default losses driving the Basic Data Set bond fund returns
- A graph of the percentage of scenarios with negative rates (at the key 10-11 points on the yield curve) or inverted yield curves (for selected rate pairs) by projection month
- Information on the prevalence of other yield curve shapes (e.g., normal, steep, inverted, humped)
- Realized interest rate volatility statistics for short and long maturities
- Equity return volatility, skew, and kurtosis statistics
- A distribution (fan chart) of equity risk premiums
- A table showing the distribution of correlations between equity returns and bond funds, interest rates and equity returns, credit spreads and equity returns over the scenario projection (correlations should be over the scenario or meaningful periods, not individual years).

IV. Comments on ESG Scenario Picker Tool, Stochastic Exclusion Ratio Test, and Data Formats

We suggest deferring discussion of these items until the scenario set itself is determined. In the meantime, we offer the following considerations:

- Since scenario selection will only be available as posted files and not a tool, clarification on how scenario selection will be implemented for companies licensing the API should be provided.
- Documentation on how the new SERT percentiles are applied (e.g., to return vs. accumulation factor distributions, the conditional versions of those distributions based on the GEMS cascade structure (and therefore available only to Conning) and whether the approach captures the range of scenario outcomes intended for SERT (e.g., low rates/high equity leads to low rates/high equity given low rates (= lower equity))].

V. Comments on Other Related Topics

- Governance: We agree with Conning on the importance of appropriate governance in this process. We would encourage as much of the ESG specifications to be incorporated into the Valuation Manual as possible. Appropriate items to consider include the setting
Appendix One

Desirable Properties of the Economic Scenario Generator

Stochastic Scenario Properties

- A single set of economic scenario requirements should apply to all products for which stochastic modeling is required.

- The prescribed scenario generator should be “fit for purpose” and produce a reasonable baseline set of economic scenarios. There should be a balance between complexity, transparency, and ease of use, and stability of scenario generator parameters.

- The scenario generator should have a sound fundamental basis. The generator parameterization should be based on relevant historical experience and produce a realistic distribution of real-world scenarios, including plausible and coherent tail stresses.

- The scenario generator should be based on best estimate assumptions to avoid unintended consequences between different products. For example, FIAs may have upside risk that would not be captured if the scenario parameters reflect additional margins geared towards products more sensitive to downside risk, such as VA GMxBs.

- The scenario generator should be viewed holistically, rather than focusing on narrow aspects of the generator. Refinements to the scenario generator should not be biased in one direction.

- Economic elements should be internally consistent. Bond fund returns should be consistent with the stochastic generator’s interest rate and credit assumptions or guidance.

- Updated generator parameterizations and their impacts on scenarios and results should be intuitive/explainable. The parameterizations should be stable.

- The scenarios should reflect initial market conditions where applicable and should not be disproportionately impacted in the long-term by initial market conditions. For example, the generator starts at the initial actual treasury rate curve and credit spreads when projecting both interest rates and bond fund returns.

Stochastic Scenario Governance

- Governance rules should be established for both routine updates (i.e. updating starting yield curve with recent actual results, calibration criteria, etc.) and periodic holistic review/validation of the generator.
  
  - Reviews and updates should be performed by a third party, vetted for complex interactions between the parameters and potentially significant impacts, and documented in sufficient detail for independent review.
  
  - The initial development process of the scenario generator should allow adequate time and resources for field testing to ensure all intended stochastic scenario properties are met.
  
  - Updates should allow for attributions, and field testing should be considered for more substantial changes.

- Non-prescribed generators should be permitted, subject to appropriate governance. Calibration criteria should be developed by the vendor so that the prescribed generator and non-prescribed
generators can be validated based on scenarios produced rather than reserve and capital results. Different scenario generators and/or parameters may produce a materially similar distribution of scenarios and results.

- Other stochastic scenario uses (e.g., hedging, ALM, risk management) may require more sophisticated economic scenario modeling (e.g., explicit credit spread, default, and migration modeling). Allowing companies to use their risk management generators for act valuation, provided the scenarios meet specific criteria for all elements included in the prescribed scenario generator, promotes better risk management without imposing unnecessary complexity on all statutory scenario stakeholders (i.e., companies and regulators).

**Production Implementation Requirements**

- The prescribed generator must automatically output prescribed scenarios in a common electronic format.

- The prescribed generator should be open source and sufficiently documented so that companies can call or otherwise implement the generator in their valuation, projections/forecasting, or risk management models. Providing just pre-generated scenarios on a quarterly basis is not sufficient to satisfy all of these purposes.

- Additional scenario tools should also be considered for development.
  - Representative scenario picking tool
  - Tool that generates the VM-21 Company-Specific Market Path method scenarios
  - Tool to generate scenarios for stochastic exclusion test
  - Tools to generate statistics on intermediate and final output of the generator.
of parameters, distribution properties, validation of results, and how the scenarios evolve through time. This will ensure appropriate controls of ESG changes and codify formulaic requirements and decision points that may be revisited over time. This work can begin while we are waiting on additional documentation.

- **Scenario timing**: We request assurance that the generator will be able to produce scenarios on the first day of each month, regardless of whether this falls on a weekend since many valuation processes commence based on a calendar day schedule.

- **Projection Period**: The projection period of the scenarios should be at least 70 years.

- **Sensitivity testing and forecasting**: It is unclear how scenarios for VM-20, VM-21, and VM-31 sensitivity testing requirements and potential attributions in Model Audit Rule key controls will be supported by the proposed process. For example, will additional scenario sets be generated and posted, or will companies be required to license the Conning API or full system to meet regulatory requirements or to understand and prudently manage their reserves and capital? The impact of changing economic conditions on the resulting scenario distribution will be vital for companies to understand for multiple reasons, including risk management & capital planning.

- **C-3 Phase 1 (C3P1) RBC testing**: Methodology clarifications will be needed if C3P1 is included in the ESG field study. Given the ongoing VM-22 discussions and their potential impact on C3P1 methodology, there are additional issues that may need to be addressed as part of the VM-22 field testing.

- **C-3 Phase 2 (C3P2) CTE Level**: We note that the revisions to C3P2 included the consideration of a scenario set with higher volatility, which was accompanied by a lower suggested CTE level (this is the CTE 95 vs CTE 98 discussion related to C3P2 TAR). Given that these decision points were contemplated as a package, the required CTE levels may need to be reconsidered in light of changes to the ESG.

We look forward to a discussion on this important initiative.

Sincerely,

cc: Reggie Mazyck, NAIC
    Dave Fleming, NAIC
DATE: March 22, 2021
FROM: Aaron Sarfatti, Chief Risk Officer; Steve Tizzoni, Head of Actuarial Regulatory Affairs
SUBJECT: Equitable Comments on Economic Scenario Generator (ESG) Proposal

**Executive Summary**

Equitable appreciates the opportunity to comment on the Economic Scenario Generator exposures. The table below summarizes our viewpoints and comments on the exposed 12/31/19 scenario set, with more detail on select items following in the remainder of this letter.

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<tr>
<th>Topic</th>
<th>Equitable Position</th>
<th>Rationale / Commentary</th>
</tr>
</thead>
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<td>Modeling methodology</td>
<td></td>
<td></td>
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<tr>
<td>GEMS Interest Rate Model (Form)</td>
<td>Favorable</td>
<td>+ GEMS functional form enables tailoring of distributions and is superior to current ESG</td>
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<tr>
<td></td>
<td></td>
<td>+ Enables arbitrage-free (or close to), which is appropriate for interest rates</td>
</tr>
<tr>
<td>GEMS Interest Rate Model (Calibration)</td>
<td>Adequate distribution of rates in 12/31/19 set, but select rates are “too negative”</td>
<td>+ Adequate share of low-for-long in the 12/31/19 scenario set</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Rates as low as -6% are too extreme (Europe since 2008 a better downside benchmark)</td>
</tr>
<tr>
<td>Equity Return Model (Form)</td>
<td>Favorable</td>
<td>+ GEMS functional form enables tailoring of distribution to stylized facts and historical equity markets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+ Ability to reflect market jumps and volatility clustering</td>
</tr>
<tr>
<td>Equity Return Model (Calibration)</td>
<td>Some concern regarding distribution of returns</td>
<td>- EAFE index returns meaningfully below US returns on a risk-adjusted basis</td>
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<td></td>
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<td>- Wide equity tails will disadvantage equity risk vs. correlated long-term credit risk</td>
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<tr>
<td>Alternate starting environments</td>
<td>Favorable</td>
<td>* Recommend releasing scenarios under other conditions beyond 12/31/19 and 12/31/20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Purpose is to 1) verify that favorable properties hold in other market conditions and 2) understand how scenarios react to different starting market conditions</td>
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<tr>
<td>Process and documentation</td>
<td></td>
<td></td>
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<tr>
<td>ESG Summary Reports</td>
<td>Addition of select exhibits will facilitate effective review</td>
<td>* Recommend exhibits summarizing distribution of average long-term UST rates and cumulative equity returns (see below)</td>
</tr>
<tr>
<td>Documentation</td>
<td>Continue expanding documentation</td>
<td>* Recommend additional documentation as delineated in ACLI comment letter</td>
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Technical Review of Scenario Sets #1 (Original) and #2 (Revised Baseline): Equitable has reviewed the original 12/31/19 scenario set (exposed in December 2020) as well as the revised 12/31/19 baseline set (exposed in February 2021) and offers the following feedback:

Distribution of Interest Rate Scenarios: Equitable believes that it is critical to have an appropriate distribution of interest rate scenarios in order for this initiative to be successful. This includes appropriate (1) low interest rate levels; (2) negative interest rate levels/amounts; and (3) interest rate shapes.

(1) Low Interest Rates: The original and revised baseline interest rate scenarios, both as of 12/31/19, were calibrated using the mean reversion parameter (MRP) from the current Academy Interest Rate Generator (AIRG) but using the substantially higher GEMS volatility. This calibration significantly increases the number of sustained low interest rate scenarios. Under this calibration, approximately one fifth of scenarios have an average 20-year treasury rate at or below 2%, below the actual 20-year treasury rate of 2.25% at 12/31/19. In contrast, under the current AIRG, less than 2% of scenarios have an average 20-year treasury rate at or below 2%. Equitable commends the NAIC on the increase in low interest rate scenarios, as we believe the current AIRG is woefully insufficient in this regard.

(2) Negative Interest Rates: Equitable reviewed the scenarios for negative interest rates and found that the minimum short-term interest rates approached -4.8% (original scenario set) and -6.2% (revised baseline), which is extreme and would likely lead market participants to take extreme actions (e.g. physical cash hoarding, etc.) if they persisted for any meaningful amount of time. Equitable believes that the recent European experience with negative rates is a reasonable benchmark to establish a lower bound on negative rates.

(3) Term Structure of Interest Rates: Equitable observed a significant number of scenarios with inverted yield curves, especially at the shorter maturities, which seems anomalous. Under the revised scenario set, we observed a 1-month UST rate above the 2-yr UST rate in approximately 25% of time steps across all scenarios. While the revised scenarios are significantly improved vs. the original scenarios in this regard, the amount of yield curve inversions is still above what one would expect based on historical experience. Equitable encourages further discussion between industry and regulators on this topic.

Equity Returns:

Equitable supports most aspects of the equity return distributions but observes select deviations in the Sharpe Ratio “return-for-risk” principle in select areas. Our specific comments are noted below:

(1) Equitable observed a significant increase in the range of 30-yr annualized equity returns to the downside vs. those in the current AIRG. In particular, under the revised scenario set, approximately 5% of the observed 30-yr annualized equity returns for the S&P 500 were negative. While we believe such a distribution is within the realm of plausibility, we highlight that combined with a CTE 98 capital requirement (which considers the worst 2% of scenarios) this will ultimately require companies either to (a) capitalize for equity risk far more than for equivalent levels of credit risk (a correlated exposure to equities) or (b) increase equity hedging considerably in their CDHS. We observe the US has not witnessed a period of negative 30-yr equity returns in modern history, inclusive of the Great Depression, although such conditions did arise in Japan.

(2) Equitable also observed extreme results for the international equity index (EAFE), where over 10% of the observed scenarios exhibited negative 30-yr annualized returns and the average 30-yr
annualized equity return was only 3.5% - ostensibly a violation of the VM-21 Section 8.C guidance regarding consistency in the Market Price of Risk across indices. Equitable suggests more supporting documentation and discussion on the EAFE equity returns.

(3) Equitable supports the structural linkage between interest rates and equity returns via an equity risk premium as utilized in the exposed GEMS scenarios. We understand that in the current model, equity returns are based on short-term interest rates, which could potentially lead to some of the more extreme equity return scenarios noted above. We would invite the consideration of expressing equity returns as a function of longer-term interest rates (e.g. 10-yr or 20-yr US Treasury rates) as that could help stabilize equity returns from calibration to calibration. In addition, we believe more information regarding how the equity risk premia for each equity index are calibrated is necessary to enable more robust understanding of the GEMS calibration.

ESG Scenario Statistics and Reports: Equitable appreciates the opportunity to provide suggestions for the ESG scenario analytics. We believe it is important to look at the distribution of average long-term (e.g. 20 yr.) treasury rates across each scenario in determining the appropriateness of the resulting interest rate scenarios and the extent to which “low for long” interest rate scenarios are reflected. To that end, we suggest the inclusion of bar charts showing the number of scenarios exhibiting average 20-yr US Treasury rate within each of the various ranges shown on the chart. In addition, we believe the following statistics would be helpful to quickly understand future scenario sets:

1. Inversion statistics: comparing points on the yield curve such as the 10Y vs. 2Y rates and 2Y vs. 1-Mo. rates to understand how many scenarios produce inverted yield curves
2. Negative interest rate statistics: examining the frequency / magnitude of negative interest rates
3. Percentile analysis of the 30-year average annualized equity returns across each of the 10,000 scenarios. It is important to look at the cumulative equity return across each scenario as the cumulative return is more impactful to the valuation of long-term insurance liabilities vs. the distribution of returns in any one given year.

Sensitivity Testing: Equitable appreciates the ESG parameter sensitivity testing supplied by Conning in February. However, we believe more sensitivity testing of various initial market conditions should be performed, including both upward and downward shocks to the initial yield curve and initial equity volatility parameters. Testing the generator under a variety of economic conditions will allow industry and regulators to better understand the potential movements of the scenarios, which is critical considering the impact the scenarios can have to a company’s balance sheet. While Equitable appreciates that the NAIC will release other scenarios for testing purposes, Equitable suggests making these available as soon as practicable to (1) allow industry to understand how the proposed ESG performs under a range of market conditions and (2) enable robust field testing.

Initial Review of 12/31/2020 baseline scenario set: Equitable is currently reviewing the 12/31/2020 scenario set released on March 18th and appreciates the release of this scenario set in response to our inquiry. Our preliminary indication is that the majority of our comments above are still relevant to the 12/31/2020 scenario set with the key exception that “low for long” scenarios are not as well reflected in this scenario set. Specifically, in the 2019 set, approximately one fifth of scenarios had an average 20-year treasury rate at or below the 2.25% 20-year treasury rate on 12/31/19. In contrast, in the 12/31/20 scenario set, only 6% of scenarios have an average 20-year treasury rate below the 1.45% 20-year treasury rate on 12/31/20. Equitable recommends that the scenario calibration approach should ensure a meaningful percentage of scenarios reflecting average long term rates below the current rate on the valuation date regardless of starting conditions. Assigning a 6% probability that interest rates stay at or below current levels appears low given the high degree of uncertainty in accurately forecasting interest rates.
Timeline/Effective Date: Equitable is aligned with the NAIC’s urgency on this matter and current goal for 1/1/2022 implementation. However, developing and calibrating a scenario generator is proving to be a very complex task and ensuring the new ESG is appropriately calibrated and fit for purpose is paramount and potentially may require additional time beyond the current timeline.

Conclusion: Equitable appreciates the opportunity to comment on the ESG proposal and we look forward to working with industry and regulators to develop an appropriate economic scenario generator. We are available to discuss our comments further at your convenience.

Sincerely,

Aaron Sarfatti, Chief Risk Officer and Chief Strategy Officer

Stephen Tizzoni, Head of Actuarial Regulatory Affairs
March 25, 2021

Mr. Mike Boerner
Chair, Life Actuarial (A) Task Force
National Association of Insurance Commissioners

Dear Mr. Boerner:

We appreciate the opportunity to offer comments on LATF’s Economic Scenario Generator (ESG) exposures including Scenario Exposure 3.18.21.

In our opinion, the interest rate scenarios that have been released exhibit some peculiar features. Two features of these scenarios we consider troublesome are the magnitude of negative interest rates and the shape and frequency of yield curve inversion. As you know, a generally accepted rule of thumb in economic scenario generation is that a good economic scenario generator should generate some “extreme but plausible scenarios” with the practical application of this rule guided by the historical record. Negative interest rates with a magnitude of -5% are not compatible with any reasonable interpretation of the historical record.

The new NAIC interest rate model is based on the three-factor Cox, Ingersoll, and Ross framework which has the potential to provide great educational value for the industry, the peculiarity of the exposed scenarios notwithstanding. The Cox, Ingersoll, and Ross model was the first interest rate model to be based on a general equilibrium economy and featured volatility increasing with interest rate levels and the absence of negative interest rates - a condition previously viewed as a desirable feature.

We believe the NAIC should seize the opportunity to guide the insurance industry to a practical understanding of the financial economics modeling literature and its application to insurance risk management. In order for industry to understand these models, it is vital that “[f]ull documentation on the ESG specifications, calibration, and tools” be provided as the NAIC stipulated in section II.A.I of the March 4, 2020 RFP and was reiterated in Pat Allison’s NAIC presentation of October 27, 2020 as “[f]ull documentation of the necessary components used to develop the Basic Data Set.” We do not know precisely what the NAIC means by “full documentation”. However, we respectfully submit that it should mean that sufficient details are provided so that a determined risk management professional is able to fully understand the model dynamics and be able to approximately reproduce the model output and calibration parameters through a scientific process. We believe this is a requirement for best practice and is essential for the industry to gain confidence in any suite of models serving a fundamental role in the management of an insurance business.

The “NAIC Scenario Set Technical Documentation Interest Rates Model” provides bond pricing formulas but does not mention market price of risk parameters and their role in the model nor how the initial state variables are selected. These two specifications are vital in understanding the model. Market price of risk parameters are typically an essential aspect of this class of interest rate model and are
fundamental in controlling the behavior and performance of the model. The “NAIC Scenario Set Technical Documentation Equity and Dividend Model” provides an equation for the equity dynamics but does not explain how the variable jump sizes in the equity and dividend processes are modeled. These are surely fundamental components of the model and represent a very significant change from the equity model currently in use. The nature of the “government bond yield” used in the dividend process is not stipulated. The means by which equity returns and jumps are correlated/related across the S&P 500, Russell Midcap, Russell 2000, NASDAQ, MSCI EAFE and MSCI Emerging Market indices are not explained. These specifications are vital in understanding the model. The “NAIC Scenario Set Technical Documentation Corporate Yield Model” is introductory, with no meaningful specification of the model given.

Guiding the insurance industry to a working understanding of modern interest rate modeling is a valuable service to the industry and we are hopeful that it will be one of the successful outcomes of the NAIC’s new model.

Yours truly,

Mark Tenney                                      Hal Pedersen, ASA, MAAA, PhD

PS This letter represents our personal opinions and not those of the Academy of Actuaries or our employers.
March 22, 2021

Comment on Conning GEMS ESG

Mr. Mike Boerner

Chair, Life Actuarial (A) Task Force

National Association of Insurance Commissioners

Dear Mr. Boerner:

We appreciate the opportunity to offer comments on LATF’s Economic Scenario Generator (ESG) exposures including Scenario Exposure 3.18.21.

The Conning GEMS model based on the 3 factor Cox, Ingersoll, and Ross model is a very awkward basis for an economic scenario generator. We developed the original economic scenario generator in the 1990s. Papers on multiple factor CIR models already existed at that time.

Mark and I did not pursue those for the original ESG work because those models are very limited in their relation to other variables. The 3 factors of the CIR model are not even correlated to each other. How they are correlated to equity portfolio returns is problematic, this is also true for credit models. So far, this has not been disclosed by Conning.

An approach that would retain more of the benefits of our original ESG work would be one based on the ideas in the Double Mean Reverting Process. In the DMRP, the short rate is mean reverting to a moving target. The moving target moves towards a fixed target. An analogy is the following. The dog chases the rabbit which tries to get to the hole. But both are on ice, so they skid around randomly. Further developments along this line would give more flexibility both as to an interest rate model and for correlation to equity returns. This type of generator is very flexible and allows the attachment of additional economic series, such as stock, credit, inflation, mortgage and GDP.

We respectfully suggest that the NAIC look in this direction instead of the Conning GEMS model. We believe the Conning model will put the NAIC into the wrong hole at a time when the industry can’t afford another skid.

Sincerely yours,

Steven Craighead

Mark Tenney

PS. This represents our opinions as individuals and not the Academy of Actuaries or any employer.
Hello all –

Scott, thanks very much for the response below about longer projection periods, which was Question 2 of Section F of the 3/10/2021 ESG Q&A. The response also relates somewhat to Question 6 about stratification. We appreciate the enhancement mentioned below to use the stratification process, rather than the response to Question 6 which suggested using the first so many scenarios. One further comment with respect to stratification is that if the smallest stratification was a 40 scenario subset, rather than 50, it would be a subset of the 200 scenario set and the 1000 scenario set. This could be beneficial for instances where people want to evaluate something that is too computationally intensive to do on, say, the 1000 scenario set, such as nested reserve or RBC calculations or some structured security projection models. The “subset property” would enable people to see the effects of the computationally intensive item across the full spectrum of outcomes for a larger set. This could be helpful in estimating effects across all scenarios. In addition, a 50 scenario set is likely not adequate on its own for estimating metrics such as CTE 90 or CTE 98. Thus we would suggest consideration of changing the 50 scenario subset to a 40 scenario subset.

Question 2 related to formatting. Here it may be helpful to have scenarios available in the current format, as suggested, but it is also helpful to the additional indices and data points available for the “full Conning format”. Thus we would suggest consideration of providing two scenario formats. It would also be helpful to have some sort of format identification number, so that people can code up checks on what format they have. Here it would also be helpful to assign a new identification number any time a format is changed.

Lastly, we believe a 9/30/2020 valuation date would be a good choice for the “next additional valuation date”, as this is the date most common to CFT and C-3 Phase 1 testing.

Thanks,
Link
Hi Reggie,

Thank you for all of your efforts to date in working with Moody’s Analytics and Conning to respond to our comments and questions.

We have some additional concerns below specific to the Scenario Picker Tool and Stochastic Exclusion Ratio Test (SERT) scenarios that have been exposed:

**Scenario Picker Tool:**

Two issues are preventing us from reconciling to the scenarios that Conning picked in the latest Dec. 2020 sample set:

1. Conning ranked significance measures from low to high before picking. The picking method embedded in the Academy’s Excel tool ranks from high to low. This opposite ranking order results in different scenario #’s being picked (i.e. ranked scenarios #5, 15, 25, ... 9995 for the subset of 1,000 scenarios).
2. Conning calculated significance measure using some unrounded data. We calculated significance measures using the level of accuracy provided in the static CSV files, which has Treasury rates rounded to 5 decimal places. In the Dec. 2020 sample subset of 1,000 picked scenarios (exposed March 18th), the rounding impacts resulted in only 890 of the 1,000 scenarios matching. 110 scenarios change if you use rounded data vs. unrounded data.

The second issue is of greater importance because end users will not have access to the unrounded data. We believe it would be beneficial to the industry if both of these issues could be resolved, for consistency and validation purposes.

**Stochastic Exclusion Ratio Test:**

We are concerned about the practicality of the targeted percentile approach for dynamically generating these scenarios at future points in time. Is this something that the API can currently do, and if so, how efficient is the runtime? Being able to dynamically project scenario #12 for the calculation of future VM-20 Deterministic Reserves if of particular concern.

We have been able to reconcile some of the data that has been provided in the sample files, but in other areas we would like to request further documentation:

1. Can you confirm that for native equity funds, the target percentiles are applied to wealth accumulation factors at each projection month?
2. For the additional equity funds and corporate bond funds, can you provide documentation about how the “GEMS User Path Technology” calculates these returns based on the user-specified inputs to Treasury and native equity funds?
3. For the inverted yield curve scenario #10, can you provide further documentation about how the targeted percentiles are applied to the spread between short and long term rates? Is the 20 year long rate set to the 50th percentile, with the targeted spread applied to the 1 year short rate?
Additionally, we would note that there appears to be a mistake in the generation of scenario #14 and #15:

4. Scenario #14 is supposed to be a delayed pop up interest / low equity scenario, but appears to be a delayed pop down interest / low equity scenario, making it a duplicate of scenario #16
5. Scenario #15 is supposed to be a delayed pop down interest / high equity scenario, but appears to be a delayed pop up interest / low equity scenario, making it a duplicate of scenario #13

Thanks again for your consideration of our comments and questions.

Regards,

Matt Kauffman, FSA
Asst. Director-Sr. Programmer & Actuary
416.250.2058 tel
Matt.Kauffman@moodys.com
<table>
<thead>
<tr>
<th>Item #</th>
<th>Source</th>
<th>Question</th>
<th>Type</th>
<th>Addressed?</th>
<th>If so, where?</th>
</tr>
</thead>
</table>
| 1     | ACLI   | Criteria / stylized facts / distribution properties  
   a. What criteria or stylized facts did Conning apply and how did they assess the pros/cons when selecting / developing their ESG model?  
   b. How does Conning assess the reasonableness of scenario outputs (i.e., in the exposed scenarios and on an ongoing basis)?  
   c. What adjustments have been made either in model development or during the generation of scenarios as a result of these considerations?  
   [Comprehensive information on these items should also be included in Conning’s documentation.] | Question     | Partial    | ESG Goals; Model Selection Slides |
| 2     | ACLI   | It seems like the selected model and proposed calibration approach may increase procyclicality (and/or create unintuitive relationships). How did that factor into the model decisions and recommendation? | Question     | No         | Expect this to be part of the Field Test |
| 3     | ACLI   | Documentation Request  
   Please provide greater specifics about the processes, distributions, etc. Such information needed includes:  
   a. Model selection considerations  
   b. Direct and indirect relationships (e.g., equity risk premium, equity / credit, rate / spread relationships)  
   c. Fund return mechanics - including the composition of bond indices and derivation of bond fund returns, use / modeling of exchange rates in international equity returns  
   d. State process information - including all distributions and correlation structures  
   e. Calibration information - including model parameters and calibration targets at multiple points in time; methodologies for setting initial values and long-term targets; how and where historical data is used and the benchmarks used; adjustment processes / use of judgment; process and judgment used when a calibration fails; identification of the values that would be updated at each reporting period, regularly, or based only on triggering events  
   f. Process and criteria for evaluating the reasonableness each published scenario distribution (beyond validating that targets are reproduced) | Documentation Request | Partial    | Bond Fund Returns; ESG Q&A, Section C, Q8, Model Selection slides |
| 4     | ACLI   | On the 2/25 call, Conning indicated that international equity returns use a different model. Please provide documentation for that model (as well as any FX model that may drive international returns). | Documentation Request | Yes | International Equity Indices Presentation |
| 5     | ACLI   | Documentation Request  
   It would be beneficial for Conning to provide more meaningful statistics, both in the presentations and in the report packages that accompany the exposed scenarios sets and sensitivities.  
   a. Equity returns in the presentations and fan charts should focus on the distribution of accumulation factors over time. This information is more relevant that annual returns in a single year.  
   b. Given the interrelationship between Conning’s models, fan charts / statistics should be provided for rates, equities, bonds, and the underlying credit drivers. This information is necessary as changing interest rates will affect equity returns and perhaps other aspects of the model. | Statistic Request | Yes | Available in Fan Charts for the 12/31/20 “Revised Baseline” Scenarios |
<p>| 6     | ACLI   | Please provide the SERT scenarios based on Revised Baseline UST calibration. | Scenario Request | Yes | Available with 12/31/20 “Revised Baseline” scenarios |
| 7     | ACLI   | Please provide the scenario file and model parameters (including initial values) are also available which will make the 12/31/2010 scenarios a more useful data point in analysis. | Scenario Request | Yes | naic.conning.com/scenario_files |
| 8     | ACLI   | For a +/-25% basis change in the overnight rate, how would the accumulation factor distribution for equities change (across all periods – i.e., traditional calibration point table + additional percentiles)? Other sensitivities to individual initial conditions should also be provided (e.g., +/- initial vols since that seems to drive equity vol and jumps). | Scenario Request | Yes | ESG Q&amp;A, Section B, Q10 |
| 9     | Chris Conrad | With respect to the treasury calibration, is the optimization problem (i.e. solving for theta, kappa, displacement, etc.) a convex problem. If not how does Conning ensure that the calibration used reflects a global minimum? Is this optimization problem as configured a constrained problem? Does the optimization function contain any regularization terms? Empirically does the optimization routine exhibit sensitivity to initial conditions (it would be nice to see a monte carlo optimization to show the algorithms stability)? | Question     | Yes | ESG Q&amp;A, Section A, Q13 |
| 10    | Chris Conrad | With respect to the equity model, do the parameters vary over time to correct for the induced vol from the rates model? If this isn’t corrected for, does that mean that the equity distribution for the first timestep will accurately reflect the history but at later timesteps will not? | Question     | Yes | ESG Q&amp;A, Section B, Q9 |</p>
<table>
<thead>
<tr>
<th>Prudential</th>
<th>Question/Comment</th>
<th>Answer</th>
<th>ESG/NAIC Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>[Describe] the mechanics of Conning's calibration.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>[Discuss] Conning's model selection decision and recommended calibration, e.g., a. How did they pick this type of equity/rate linkage over other approaches, especially given that the different types can produce very different reserve/capital sensitivities? b. How did they get comfortable with the appropriateness of the changes in these sensitivities when certain LATF parameters were incorporated vs. their Standard Calibration?</td>
<td>Question</td>
<td>Methodology/NAIC</td>
</tr>
<tr>
<td>13</td>
<td>[Describe the] out of the box capabilities in GEMS to allow different relationships (vs. just substituting different parameter values)?</td>
<td>Question</td>
<td>ESG Q&amp;A, Section B, Q12</td>
</tr>
<tr>
<td>14</td>
<td>[Are there] not out-of-the-box changes that Conning would be willing to consider/implement?</td>
<td>Question</td>
<td>ESG Q&amp;A, Section B, Q12 and Q13</td>
</tr>
<tr>
<td>15</td>
<td>What would actually change on a monthly basis? a. Is Conning only updating initial conditions (and any LATF-specified formulaic updates - e.g., MRP)? b. Are the updates purely mechanical, or are there any subjective tweaks or judgment calls?</td>
<td>Question</td>
<td>No</td>
</tr>
<tr>
<td>16</td>
<td>What is the LATF exposure/testing/approval process for: a. Other regularly scheduled/routine updates beyond initial condition or formulaic updates (e.g., bringing an additional year of historical data into the calibration? b. More fundamental model changes (e.g., structural changes, changes in calibration methodology/philosophy)</td>
<td>Question</td>
<td>Yes</td>
</tr>
<tr>
<td>17</td>
<td>What is the process if something unexpected/unanticipated happens in the monthly updates - e.g., routine (business as usual) updates create scenarios that suddenly don't make sense, or the calibration produces invalid parameters? a. What is the process for reviewing and detecting questionable or inappropriate scenario distribution properties before scenarios are posted? (There should be checks for reasonability of distribution properties and not just validation that specific targets were reproduced. The scenarios exposed in Dec. reproduced LATF's / Conning's intended targets, but the process should have identified the inappropriate distribution of yield curve shapes.) b. What is the escalation process if issues are detected? (Does Conning make judgments on their own? Are regulators and industry at risk of being surprised when unusual scenarios produce unusual reported results or changes in reported results that don't align with prior sensitivities/dynamics?)</td>
<td>Question</td>
<td>No</td>
</tr>
<tr>
<td>18</td>
<td>The International Diversified Equity (MSCI EAFE) and Aggressive Foreign Equity (MSCI Emerging Market) do not have Income Returns in the sample data set. Will this be adjusted to align with the historical results for these indices?</td>
<td>Question</td>
<td>Yes</td>
</tr>
<tr>
<td>19</td>
<td>Why are bond funds assumed to only invest in industrials (not financials or industrials)?</td>
<td>Question</td>
<td>Yes</td>
</tr>
<tr>
<td>20</td>
<td>Do BBB bonds reflect a selected BBB bond, a universe of BBB+ / BBB / BBB- bonds, etc.?</td>
<td>Question</td>
<td>Yes</td>
</tr>
<tr>
<td>21</td>
<td>How are the international fund returns expressed: hedged or unhedged?</td>
<td>Question</td>
<td>Yes</td>
</tr>
<tr>
<td>22</td>
<td>How often will the parameters of the model be updated?</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>23</td>
<td>See &quot;Prudential&quot; tab</td>
<td>Question/Comment</td>
<td>No</td>
</tr>
<tr>
<td>24</td>
<td>How are the jump parameters determined and/or set? Does the model reflect recent jump data or long-term averages or a combination of both? Looking at historical data, how does the model determine when a jump has occurred and the magnitude of the jump? For example, considering the movement in the S&amp;P 500 during the first couple of quarters of 2020, was this considered a jump or multiple jumps? If so, what was the criteria used to determine if a jump occurred? Over how many days was the jump considered to occur and what was the magnitude of the jump?</td>
<td>Question</td>
<td>Yes</td>
</tr>
<tr>
<td>25</td>
<td>How is the value of the mean reversion speed parameter in the Variance Equation determined?</td>
<td>Question</td>
<td>Yes</td>
</tr>
<tr>
<td>Page</td>
<td>Name</td>
<td>Question</td>
<td>Answer</td>
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<tr>
<td>26</td>
<td>Jason Kehrberg</td>
<td>a. What are the starting state variables?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. What is the initial spread function, i.e., forward rate residual curve, and what has it decayed to at year 1?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. The residual forward spread at year 1 what was fitted at time zero, or is the time zero spread moved forward to year 1?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d. What was the biggest upward jump and the biggest downward jump?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>e. Is the revision to the baseline on 4/8/21 needed?</td>
<td>Yes</td>
</tr>
<tr>
<td>27</td>
<td>Jason Kehrberg</td>
<td>a. Is a month 1/12 of a year (delta t = 1/12)?</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. How many weeks are there in a month (delta t = 1/48)?</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Is the forward rate residual curve used in the same calendar rules used to simulate the Q3?</td>
<td>No</td>
</tr>
<tr>
<td>28</td>
<td>Jason Kehrberg</td>
<td>a. Can the equity and bond returns on the 7 alternative Treasury calibrations be used to run the 7 alternative Treasury calibrations on 2/4/21?</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Can the additional sensitivity of the 7 alternative Treasury calibrations be used to provide additional insight into how equity and bond returns change when interest rates and volatilities change?</td>
<td>No</td>
</tr>
<tr>
<td>29</td>
<td>Link Richardson</td>
<td>a. Are the 3 year and 30 year &quot;columns&quot; annualized returns?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Are the 3 year and 30 year &quot;columns&quot; annualized returns?</td>
<td>Yes</td>
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<tr>
<td></td>
<td></td>
<td>c. Are the 3 year and 30 year &quot;columns&quot; annualized returns?</td>
<td>Yes</td>
</tr>
<tr>
<td>30</td>
<td>Link Richardson</td>
<td>a. What is the state of the model at year 1?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. What is the state of the model at year 1?</td>
<td>Yes</td>
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<tr>
<td></td>
<td></td>
<td>c. What is the state of the model at year 1?</td>
<td>Yes</td>
</tr>
<tr>
<td>31</td>
<td>Link Richardson</td>
<td>a. What is the state of the model at year 1?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. What is the state of the model at year 1?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. What is the state of the model at year 1?</td>
<td>Yes</td>
</tr>
<tr>
<td>32</td>
<td>Mark Tenney</td>
<td>a. In the target formula, it looks like Theta and Lambda are added together in the targets. Why is there a separate parameter for each?</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. In the target formula, it looks like Theta and Lambda are added together in the targets. Why is there a separate parameter for each?</td>
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<td></td>
<td></td>
<td>c. In the target formula, it looks like Theta and Lambda are added together in the targets. Why is there a separate parameter for each?</td>
<td>No</td>
</tr>
<tr>
<td>33</td>
<td>Mark Tenney</td>
<td>a. Does the model predict the mean reversion speed and level of the embedded risk neutral model (i.e., the model without Lambda and Lambda)?</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Does the model predict the mean reversion speed and level of the embedded risk neutral model (i.e., the model without Lambda and Lambda)?</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>c. Does the model predict the mean reversion speed and level of the embedded risk neutral model (i.e., the model without Lambda and Lambda)?</td>
<td>No</td>
</tr>
<tr>
<td>34</td>
<td>Mark Tenney</td>
<td>a. How does the GEMs model ensure that those boundaries are violated?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. How does the GEMs model ensure that those boundaries are violated?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. How does the GEMs model ensure that those boundaries are violated?</td>
<td>Yes</td>
</tr>
<tr>
<td>35</td>
<td>Mark Tenney</td>
<td>a. See &quot;Mark Tenney&quot; tab, &quot;Mark Tenney Questions 3/8/21&quot;</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. See &quot;Mark Tenney&quot; tab, &quot;Mark Tenney Questions 3/8/21&quot;</td>
<td>Yes</td>
</tr>
<tr>
<td>36</td>
<td>Mark Tenney</td>
<td>a. See &quot;Mark Tenney&quot; tab, &quot;Mark Tenney Questions 3/8/21&quot;</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. See &quot;Mark Tenney&quot; tab, &quot;Mark Tenney Questions 3/8/21&quot;</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. See &quot;Mark Tenney&quot; tab, &quot;Mark Tenney Questions 3/8/21&quot;</td>
<td>Yes</td>
</tr>
<tr>
<td>37</td>
<td>Matt Kaufman</td>
<td>a. Does the API accept a starting yield curve?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Does the API accept a starting yield curve?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Does the API accept a starting yield curve?</td>
<td>Yes</td>
</tr>
<tr>
<td>38</td>
<td>Matt Kaufman</td>
<td>a. Does the GEMs model require the initial state variables to be negative?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Does the GEMs model require the initial state variables to be negative?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Does the GEMs model require the initial state variables to be negative?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. See &quot;Moody's Analytics&quot; tab, &quot;Moody's Analytics Questions 3/8/21&quot;</td>
<td>No</td>
</tr>
<tr>
<td>40</td>
<td>Scott Schneider</td>
<td>a. Will scenarios be consistent from month to month?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Will scenarios be consistent from month to month?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Will scenarios be consistent from month to month?</td>
<td>Yes</td>
</tr>
<tr>
<td>41</td>
<td>Scott Schneider</td>
<td>a. When parameters are updated, will Conning provide scenarios as of the valuation date before or after changing each parameter?</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. When parameters are updated, will Conning provide scenarios as of the valuation date before or after changing each parameter?</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. When parameters are updated, will Conning provide scenarios as of the valuation date before or after changing each parameter?</td>
<td>No</td>
</tr>
<tr>
<td>42</td>
<td>Scott Schneider</td>
<td>a. If 10,000 scenarios are not enough for convergence (particularly for CTE98), what do we do?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. If 10,000 scenarios are not enough for convergence (particularly for CTE98), what do we do?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. If 10,000 scenarios are not enough for convergence (particularly for CTE98), what do we do?</td>
<td>Yes</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
<td>Section</td>
<td>Comments</td>
</tr>
<tr>
<td>----------</td>
<td>--------</td>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td>43 Scott Schneider</td>
<td>Question</td>
<td>Yes</td>
<td>ESG Q&amp;A, Section F, Q7</td>
</tr>
<tr>
<td>44 Scott Schneider</td>
<td>Question</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>45 Scott Schneider</td>
<td>Question</td>
<td>Yes</td>
<td>ESG Q&amp;A, Section B, Q6</td>
</tr>
<tr>
<td>46 Seong-min Eom</td>
<td>Scenario Request</td>
<td>Yes</td>
<td>Posted to naic.conning.com/scenariofiles 2/24/2021</td>
</tr>
<tr>
<td>47 Seong-min Eom</td>
<td>Statistic Request</td>
<td>Yes</td>
<td>These new charts can be seen in the fan charts for the 12/31/20 “Revised Baseline” scenarios</td>
</tr>
<tr>
<td>48 Steve Tizzone</td>
<td>Question</td>
<td>Yes</td>
<td>ESG Q&amp;A, Section B, Q11</td>
</tr>
<tr>
<td>49 Steve Tizzone</td>
<td>Question</td>
<td>Yes</td>
<td>naic.conning.com/scenariofiles 2/24/2021</td>
</tr>
<tr>
<td>50 Ted Chang</td>
<td>Question</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>51 Tim Finnegan</td>
<td>Comment</td>
<td>Yes</td>
<td>ESG Common Comment Themes Presentation, LATF 4/8/21</td>
</tr>
<tr>
<td>52 Tim Finnegan</td>
<td>Comment</td>
<td>Yes</td>
<td>ESG Common Comment Themes Presentation, LATF 4/8/21</td>
</tr>
</tbody>
</table>
In the graph "Equity Equation – Impact of Jumps" on page 10 of the ppt slides, the projected cumulative wealth factors from AIRG and GEMS at the end of the 30th year can be approximated by the line

\[
\text{AIRG cumulative wealth factor} = 1.3082 \times (\text{GEMS cumulative wealth factor}) + 1.4558
\]

For example, if GEMS cumulative factor is 4500%, the AIRG cumulative factor is approximately 6000%.

Please explain the driver(s) which cause AIRG's cumulative wealth factor being significantly higher than GEMS's cumulative factor.

Given that the title of the slide is "Equity Equation – Impact of Jumps," is the difference in wealth factors attributable to the assumed jumps? If not, why?

---

### Question 53

**Question**

Does it mean that the jump parameters would reduce the drifting factor for the equity return?

**Answer**

Yes

**ESG Q&A, Section B, Q4**

---

### Question 54

**Question**

As the jump parameters \( \mu_0 \) and \( \mu_1 \) are positive and \( m \) is negative in page 8, the drifting factor due to the jump parameters is negative. Does it mean that the jump parameters would reduce the drifting factor for the equity return?

**Answer**

Yes

**ESG Q&A, Section B, Q5**
Society of Actuaries Research Update to LATF

R. DALE HALL, FSA, MAAA, CERA, CFA
Managing Director of Research
April 8, 2021

Presentation Disclaimer

The material and information contained in this presentation is for general information only. It does not replace independent professional judgment and should not be used as the basis for making any business, legal or other decisions. The Society of Actuaries assumes no responsibility for the content, accuracy or completeness of the information presented.
Group Life COVID-19 Mortality Survey

- Survey of claims experience of 20 of top 21 U.S. Group Term Life insurers during the COVID-19 pandemic
- Data through October 2020 (report to be updated in June)
- Measured overall excess mortality and portion of excess mortality due to COVID
- Analyzed results by geographic region, industry, and against the U.S. population as a whole
Group Life COVID-19 Mortality Survey

• Survey Highlights
  • Q2 & Q3 2020 incurred incidence compared to corresponding quarters of 2017-2019
    • By count: 12.9% increase
    • By amount: 23.8% increase
    • 16,740 COVID claims, totaling $662 million
  • Q2 & Q3 2020 reported incidence compared to corresponding quarters of 2017-2019
    • By count: 8.5% increase
    • By amount: 20.1% increase
    • 14,513 COVID claims, totaling $564 million

Group Life COVID-19 Mortality Survey

• Survey Highlights
  • 8% of all reported Group Life claims with death dates in April-August 2020 were determined to have a cause of death of COVID-19
  • Blue Collar group has seen the smallest increase in mortality (monthly 3% - 10%). White Collar and Grey Collar have had higher increases (monthly 10% - 30%)
  • Regional patterns have changed over time
    • Northeast region affected greatest in Q2
    • Southeast region affected greatest in Q3
  • Percentage of Group Life excess deaths approximately 50% - 70% of the percentage of U.S. population excess deaths
Individual Life COVID-19 Claims Analysis

- Data
  - 27 companies’ experience
  - 55% industry
  - 2.5 million claims from 2015 through Q2 2020; 239k in 2020, 11.6k COVID claims

- Analyses
  - 2020 Q1 & Q2 actual claims vs average of 2015-2019 experience
    - Attained age, sex, region, underwriting class, smoker status, face amount, cause of death
  - 2020 Q1 & Q2 actual claims vs U.S. population
    - Attained age, sex, region, cause of death
  - [https://www.soa.org/resources/experience-studies/2021/us-individual-life-covid-19/](https://www.soa.org/resources/experience-studies/2021/us-individual-life-covid-19/)

Individual Life Mortality Claims Analysis – Some Highlights

- Overall Actual to Expected
  - Similar ratios in 2020 Q1
  - Individual life lower in 2020 Q2

<table>
<thead>
<tr>
<th>Actual to Expected</th>
<th>Individual Life</th>
<th>U.S. Population (excess death)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020 Q1</td>
<td>93-99%</td>
<td>97-101%</td>
</tr>
<tr>
<td>2020 Q2</td>
<td>110-113%</td>
<td>118-123%</td>
</tr>
</tbody>
</table>

- Average Age @ Death
  - Individual life is older
  - COVID vs non-COVID greater in population

<table>
<thead>
<tr>
<th>Average Age @ Death</th>
<th>Individual Life</th>
<th>U.S. Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID claims</td>
<td>79.5</td>
<td>76.1</td>
</tr>
<tr>
<td>Non-COVID claims</td>
<td>78.9</td>
<td>73.1</td>
</tr>
</tbody>
</table>

Underwriting Class Actual to Expected
- Preferred A/E > other classes at older ages

US Population Mortality

© 2021 National Association of Insurance Commissioners
2020 Excess Deaths in the US General Population by Age and Sex

- Expands on CDC excess death analysis
  - shows results by age group and sex breakdowns
- Enables better comparisons of population to insured experience
  - Can now adjust for age/sex differences

Interesting finding: Ages 35-54 have the highest actual/expected values
  
  https://www.soa.org/resources/research-reports/2021/excess-deaths-gen-population/

### U.S. Population Mortality Observations – Updated with 2019 Experience

- 1.2% annual improvement in 2019
- New feature - Results by 5 socioeconomic groups
- Cause of death analyses
  
  https://www.soa.org/resources/research-reports/2021/us-population-mortality/
### Additional SOA Life Research

![Society of Actuaries Logo](https://www.soa.org/resources/experience-studies/2021/us-individual-life-covid-19/)

### SOA Experience Studies

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999-2017 Post Level Term Mortality and Lapse - Report</td>
<td>Complete a study of mortality and lapse on term policies in the post level premium period.</td>
<td>4/30/2021</td>
</tr>
<tr>
<td>2000-2017 Pre level Term Mortality and Lapse - Machine Learning Report</td>
<td>Draft a report regarding the PLT machine learning analysis that was done; this report will supplement the main report.</td>
<td>4/30/2021</td>
</tr>
<tr>
<td>2009-16 Individual Life Mortality Study</td>
<td>Complete the next in a series of experience analysis of individual ordinary life insurance mortality.</td>
<td>4/30/2021</td>
</tr>
<tr>
<td>2018 Variable Annuity Guaranteed Living Benefit Utilization Study</td>
<td>Examine the utilization of guaranteed living benefit options on variable annuity policies under a Joint SOA/LIMRA project.</td>
<td>6/30/2021</td>
</tr>
<tr>
<td>Group Life COVID-19 Mortality Survey Update - Report</td>
<td>Complete an update on a mortality study assessing the impact of COVID-19 on Group life insurance.</td>
<td>6/30/2021</td>
</tr>
<tr>
<td>2000-2011 LTC Lapse and Mortality Valuation Assumptions</td>
<td>Develop a replacement mortality LTC valuation table and a proposal to replace the current LTC voluntary lapse parameters. Work done in conjunction with the AAA.</td>
<td>6/30/2021</td>
</tr>
<tr>
<td>Mortality Improvement Survey</td>
<td>Complete a survey to learn how companies are reacting to the slowdown in the level of mortality improvement within the general population.</td>
<td>6/30/2021</td>
</tr>
</tbody>
</table>


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## SOA Practice Research & Data Driven In-house Research

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020 Emerging Risks Survey-Key Findings</td>
<td>Provide highlights of the 2020 Emerging Risk Survey that tracks the trends and thoughts of risk managers across time.</td>
<td>Complete: On SOA website</td>
</tr>
<tr>
<td>2020 Excess Deaths in the U.S. General Population by Age and Sex</td>
<td>Actual to Expected Population Mortality during the COVID era.</td>
<td>Complete: On SOA website</td>
</tr>
<tr>
<td>Insurance Policies on Human Genetics Primer</td>
<td>Draft a primer paper that discusses the issues surrounding human genetics and how they are and will impact the insurance industry.</td>
<td>Complete: On SOA website</td>
</tr>
<tr>
<td>US Mortality by Socioeconomic Category - Update</td>
<td>Update the set of detailed life tables by socioeconomic category across all U.S. counties.</td>
<td>Complete: On SOA website</td>
</tr>
<tr>
<td>Complex Model Evaluation</td>
<td>Review existing literature on GLMs, discuss actuarial standards for using complex models outside of actuary’s initial expertise, develop case studies for demonstrating methods of evaluating the validation of complex models.</td>
<td>4/30/2021</td>
</tr>
<tr>
<td>Human Mortality Database - 2019 Projects</td>
<td>Enhance the Human Mortality Database by focusing on state level mortality tables and expanding causes of death mortality tables for more countries.</td>
<td>4/30/2021</td>
</tr>
<tr>
<td>InsurTech White Paper</td>
<td>Write a white paper covering the InsurTech landscape in the U.S. and discuss how actuaries will be impacted.</td>
<td>4/30/2021</td>
</tr>
<tr>
<td>Deep Learning for Liability-Driven Investments</td>
<td>Explore the possibility of using deep learning and reinforcement learning techniques to improve investment decision making for pension funds and life insurance companies.</td>
<td>5/30/2021</td>
</tr>
<tr>
<td>Managing Investment Risks of Insurance/Annuity Contractual Designs</td>
<td>Develop a framework for quantifying and analyzing various forms of contractual designs and their risk management techniques.</td>
<td>5/30/2021</td>
</tr>
<tr>
<td>2020 Emerging Risks Survey - Final Report</td>
<td>Track the trends and thoughts of risk managers on emerging risks across time.</td>
<td>6/30/2021</td>
</tr>
<tr>
<td>Predictive Analytics for Early Detection of Insurer Insolvency</td>
<td>Develop a market-based insolvency prediction model to detect financially distressed insurers at an early stage.</td>
<td>6/30/2021</td>
</tr>
</tbody>
</table>

For more information, visit:
- [2020 Emerging Risks Survey](https://www.soa.org/resources/research-reports/2020/emerging-risks-survey)
- [2020 Excess Deaths in the U.S. General Population by Age and Sex](https://www.soa.org/resources/research-reports/2020/excess-deaths-gen-population)
- [Insurance Policies on Human Genetics Primer](https://www.soa.org/resources/research-reports/2020/insurance-policies-genetics)
- [US Mortality by Socioeconomic Category - Update](https://www.soa.org/resources/research-reports/2020/us-mortality-socioeconomic)
Life Practice Council Update

Laura Hanson, MAAA, FSA
Vice President

Life Actuarial Task Force Meeting—April 8, 2021

Agenda

- Recent Activities
- Current Activities
- Ongoing Activities
Recent Activities

- Hosted 2020 year-in-review webinar
- Published 2021 *Life & Health Valuation Law Manual*
- Created six principle-based reserving (PBR) analysis templates
  - Additional content on Academy PBR webpage [https://www.actuary.org/content/pbr-practice](https://www.actuary.org/content/pbr-practice)
- Published PBR In Brief (VM-22)

Recent Activities (continued)

- Updated C-1 bond factors with new tax rate
- Created Fixed Annuity PBR Deviations Grid
- Submitted comment letters on:
  - Economic scenario generator (LATF)
  - C-1 real estate factors (LRBC)
  - Colorado Senate Bill 21-169 (Senator Buckner)
Current Activities

- VM-21 Practice Note Addendum exposed for comment through April 30
- VM-22 drafting underway; expected in Q2 2021
- VM-22/C-3 P1 field study in development

Current Activities (continued)

- COVID-19 webinar planned for May
- PBR Boot Camp June 7–9
  - Registration is open!
  - Agenda
    - Day One: External reviews of PBR, model overview and model governance, and reserve change analysis and pricing projections.
    - Day Two: Overviews of life insurance—implementation of VM-20, mortality, additional liability assumption, and reinsurance.
    - Day Three: Asset overview, standard projection methodology, and sample reports.
Ongoing Activities

- Support Economic Scenario Generator transition
- Coordinate VM-22 and C-3 field study for non-variable annuities
- Recommend C-2 mortality factors
- Provide analysis of C-1 bond factors, C-1 real estate factors, and C-2 longevity factors

Ongoing Activities (continued)

- Provide commentary on mortality improvement discussions
- Support Yearly Renewable Term (YRT) reinsurance approach for VM-20
- Propose VM-51 data elements
- Publish Life Illustrations Practice Note Addendum
- Publish FAQs on changes to tax reserve calculations and reporting under TCJA (federal tax law)
Ongoing Activities (continued)

- Provide public policy analysis on the use of annuities in retirement plans, including changes as a result of the SECURE Act
- Provide public policy analysis on the use of data and algorithms in risk classification and underwriting
- Provide public policy analysis on efforts to promote diversity and inclusion in the actuarial profession and the broader insurance industry

Thank You

- Questions?
- For more information, please contact the Academy’s Life Policy Analyst, Khloe Greenwood, at greenwood@actuary.org.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force Amendment Proposal Form*

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

Identification:
Dany Provencher, Appointed Actuary, Industrial Alliance group of companies

Title of the issue:
Asset collar when modeled reserve is negative

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

VM-20 Section 7.D.3

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

If for all model segments combined, the aggregate annual statement value of the final starting assets, less the corresponding PIMR balance, is

(a) less than 98% of the modeled reserve; or
   (i) 98% of the modeled reserve if modeled reserve is positive;
   (ii) 102% of the modeled reserve if modeled reserve is negative; or
(b) greater than the largest of:
   (i) 102% of the modeled reserve;
   (ii) the NPR for the same set of policies, net of due and deferred premiums thereon:
   and
   (iii) zero,
then the company shall provide documentation in the PBR Actuarial Report that provides reasonable assurance that the modeled reserve is not materially understated as a result of the estimate of the amount of starting assets.

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

If modeled reserve is negative, using assets corresponding to 100% of modeled reserve, would not fall within the asset collar.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.
Life Actuarial (A) Task Force/Health Actuarial (B) Task Force
Amendment Proposal Form

1. Identify yourself, your affiliation and a very brief description (title) of the issue.
   
   Brian Bayerle, ACLI – edits adopted changes to VM-02 for improved clarity and to remove potential circularity.

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

   Valuation Manual (January 1, 2021 edition), VM-02 Section 3.A

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

   See attached.

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

   Subsequent the adopted changes to the federal tax code (IRC S. 7702), this proposed change would clarify the language in the previously adopted edits to VM-02 to avoid any potential circularity.

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Valuation Manual VM-02

Section 3: Interest

A. The nonforfeiture interest rate for any life insurance policy issued in a particular calendar year beginning on and after the operative date of the Valuation Manual shall be equal to 125% of the calendar year statutory valuation interest rate defined for the NPR in the Valuation Manual for a life insurance policy with nonforfeiture values, whether or not such sections apply to such policy for valuation purposes, rounded to the nearer one-quarter of 1%, provided, however, that the nonforfeiture interest rate shall not be less than the Applicable Accumulation Test Minimum Rate in the Cash Value Accumulation Test under Section 7702 (Life Insurance Contract Defined) of the U.S. Internal Revenue Code.

Guidance Note: For flexible premium universal life insurance policies as defined in Section 3.D of the Universal Life Insurance Model Regulation (#585), this is not intended to prevent an interest rate guarantee less than the nonforfeiture interest rate.
The proposed guidance note presumes that Section 6.C.5.n refers to how cohorts and weights are unaffected by changes in interest rates at each reporting date because the discount rate for the calculations is fixed, but it indicates that periodic updates to underlying prescribed assumptions may require recalculations. LATF is requesting comments on this interpretation and its applicability to this RMD change vs. Standard Projection assumption updates more broadly.

Please submit comments to Reggie Mazyck (RMazyck@naic.org) by COB 5/3/21.
1. Identify yourself, your affiliation and a very brief description (title) of the issue.

American Academy of Actuaries, Variable Annuity Reserves & Capital Work Group

Update the reference to the required minimum distribution (RMD) age in the VM-21 Standard Projection Amount for the Setting Every Community Up for Retirement Enhancement (SECURE) Act change.

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

January 1, 2021, version of the Valuation Manual

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

In VM-21, Section 6.C.5:

i. For tax-qualified contracts, add the following to the revised GAPV$^2$ corresponding to an initial withdrawal age of 71 the federal required minimum distribution (RMD) age.

\[
0.50 \times \left\{ \begin{array}{ll}
0.95 & - \sum_{i=\text{initial age}} \text{GAPV}_{\text{Adjusted, Scaled}}^2, \text{if contract is a tax-qualified GMWB} \\
0.85 & - \sum_{i=\text{issue age}} \text{GAPV}_{\text{Adjusted, Scaled}}^2, \text{if contract is a tax-qualified hybrid GMIB}
\end{array} \right.
\]

j. Scale the revised GAPV$^2$ values at all future initial withdrawal ages—i.e., all ages greater than 71 the federal required minimum distribution (RMD) age, as identified in the preceding step—such that the sum of the revised GAPV$^2$ values equals 0.95 for tax-qualified GMWB contracts and 0.85 for tax-qualified hybrid GMIB contracts again.

n. The cohorts and their associated weights as determined in Section 6.C.5.a through Section 6.C.5.k are for a contract with attained age equal to its issue age. Because the discount rate used in this determination is fixed, generally these calculations only need to be performed once for a given set of contracts with a certain issue age, guaranteed benefit product, and tax status.

Guidance Note: Cohorts and their associated weights may need to be revised if prescribed assumptions are updated.

4. State the reason for the proposed amendment? (You may do this through an attachment.)
The Standard Projection’s withdrawal delay cohort method includes an adjustment at the required minimum distribution (RMD) age. The SECURE Act changed the RMD age from 70.5 to 72. This proposed amendment implements the change by directly referencing the RMD age. The direct reference will reduce Valuation Manual maintenance for any future changes.

The proposed guidance note presumes that Section 6.C.5.n refers to how cohorts and weights are unaffected by changes in interest rates at each reporting date because the discount rate for the calculations is fixed, but it indicates that periodic updates to underlying prescribed assumptions may require recalculations. LATF is requesting comments on this interpretation and its applicability to this RMD change vs. Standard Projection assumption updates more broadly.

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

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<th>NAIC Staff Comments:</th>
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/\National Meetings/2010.../TF/LHA/
March 26, 2021

Mr. Mike Boerner
Chair, NAIC Life Actuarial Task Force

Re: APF 2020-12

Dear Mike:

Nationwide appreciates the opportunity to comment on APF 2020-12 regarding Clearly Defined Hedging Strategies (CDHS). We are supportive of the goals of this APF to:

1. Create consistency in the hedging requirements across chapters within the Valuation Manual (VM), and
2. Encourage more consistent inclusion of hedging strategies within the VM calculation requirements.

The APF accomplishes its goals by moving hedging definitions to VM-01 and by including the newly defined Seasoned Hedging Strategies (SHS) in the VM requirements.

On page 2 of the APF in the “State the reason for the proposed amendment” section the concept of the SHS is given as:

“To accomplish this, the proposal requires that any hedging strategy that is a part of the investment strategy supporting the policies and is normally modeled as part of the company’s risk assessment and evaluation processes be modeled as if it were a CDHS if doing so results in an increase in life reserves or variable annuity TAR.”

However, the proposed definition of SHS in the APF uses slightly different language as follows:

“The term “Seasoned Hedging Strategy” (SHS) means a hedging strategy that is part of the company’s investment strategy and is normally modeled as part of the company’s risk assessment and evaluation process. A SHS may or may not be a CDHS.”

We prefer the SHS definition given on page 2 of the APF as it clearly indicates that the hedging strategy needs to be part of the investment strategy which supports the policies subject to the VM calculation requirements. We would recommend changing the SHS definition to be consistent with the language given on page 2 of the APF.

In addition, our interpretation of this APF is that it excludes company level “macro” hedges which we support. We believe that the page 2 SHS definition more clearly supports the exclusion of company level “macro” hedges from the VM calculation requirements. Company level “macro” hedges are meant to manage aggregate company level risks and not product specific risks. As such, we believe that it would not be appropriate to include them in product specific VM calculation requirements.

However, if the APF does intend to include company level “macro” hedges in the requirements, then we believe that the APF will need to be significantly expanded to include language on how this is to be accomplished. For example, how would these “macro” hedges be allocated to specific product calculation requirements across multiple chapters of the VM?
We appreciate your consideration of our comments.

Sincerely,

Philip Wunderlich, FSA, MAAA
Associate Vice President, Appointed Actuary
Nationwide Financial

Brian J. Wagner, FSA, MAAA
Associate Vice President, Actuary
Nationwide Financial

Jay Hines, FSA, MAAA
Senior Actuary, Annuity Valuation
Nationwide Financial

cc Reggie Mazyck, NAIC
Pete Weber, Ohio Department of Insurance
Brian Bayerle  
Senior Actuary  

March 26, 2020  

Mr. Mike Boerner  
Chair, NAIC Life Actuarial Task Force (LATF)  

Re: APF 2020-12  

Dear Mr. Boerner:  

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit the following comments on the exposed APF 2020-12. The APF seeks to align and consolidate hedging requirements across Valuation Manual sections, address a drafting note within VM-20, and eliminate perceived company optionality with regard to the reflection of hedging in PBR requirements.  

We support the goal of aligning and consolidating hedging requirements and are not opposed to addressing the VM-20 drafting note. We also acknowledge the legitimate regulatory concerns around perceived company optionality. At the same time, APF 2020-12 raises a number of questions and potential concerns. We believe that there is a lack of understanding among all parties of the industry’s hedging strategies, the way in which those hedging strategies are reflected in PBR modeling, and the intent and potential effects of the APF. At the extreme, we believe the APF could create a regulatory disincentive to undertake certain strategies and would lead to resource-intensive reconsideration of and revisions to hedging programs.  

We suggest that an important next step involves a broad survey of the industry’s hedging programs. The proprietary nature of hedging programs makes it difficult for the industry to collect the information about the strategies employed by the industry. Therefore, a regulator survey might be a preferable vehicle. The survey could explore the landscape of hedging programs, their intent, their treatment within PBR modeling, whether or not such programs are considered a CDHS (and if not, why not), and the potential impact of APF 2020-12. The survey itself would promote a consistent understanding of the APF and a mutual understanding of whether the APF would lead to unintended consequences.  

Regarding the understanding of the APF, our discussions have surfaced different interpretations of the language, which has potentially led to some misperceptions. For example, the phrase “normally modeled as part of a company’s risk assessment and evaluation processes” can be interpreted very broadly or narrowly. These varying interpretations have led to inconsistent understandings and interpretations of the impact of the APF among our member companies.
Because we believe there are potential unintended consequences with APF 2020-12, we believe that it may be beneficial to consider alternative solutions. ACLI believes once we have a greater mutual understanding we can work with regulators to develop an alternative that provides for enhanced regulatory oversight while addressing many of our concerns.

Finally, we would like to share the following preliminary concerns with APF 2020-12. Again, these concerns may reflect an incomplete understanding of the APF:

1. **It may create a disincentive to hedge**

   One of the crowning achievements of the new VA framework is that it has removed previous disincentives to hedge risks due to the non-economic nature of the statutory framework. APF 2020-12 might unfortunately move in the opposite direction by reintroducing non-economic disincentives into the framework. Under the proposal, hedges that are deemed to be an SHS may produce unreasonable results in statutory modeling. For SHS strategies, the company would be required to reflect the more adverse of the with-hedging and without-hedging results, thus eliminating any regulatory benefit of undertaking such a strategy. Because hedging inevitably comes with an attendant cost, the framework would effectively be signaling that insurers should not be undertaking SHS strategies. We believe that this is contrary to the interests of regulators, companies, and policyholders.

2. **It may create excessive complexity**

   APF 2020-12 could be interpreted to apply broadly to hedging strategies and, if implemented, could lead to significant questions and complications. Macro hedges might need to be allocated to the product level which could create significant practical challenges. Further, hedging programs that are established to manage statutory outcomes would lead to circularity, due to the interplay in the valuation of the reserve and the hedge. In addition, situations could arise in which multiple hedging programs would need to be reflected, creating additional layers of complexity and complication.

In addition, we believe the APF raises various other technical and practical questions. For instance, the APF is currently silent on treatment of reinsurance, which could affect how the requirements are interpreted and applied. In addition, the APF requires modeling a SHS if doing such increases the reserve but does not clarify the treatment if modeling a SHS decreases the reserve. Further to that point, if the intent is one-sided then the APF would create challenges as there would potentially be period-to-period changes in whether strategies should be reflected. This toggling would create new challenges for both companies and regulators.

We believe that industry and regulators may be better served by a different solution. Therefore, in addition to an improved understanding of the landscape of hedging programs, we believe that alternative proposals should be considered.
We appreciate the consideration of our comments and look forward to discussing on a future call. Thank you.

Sincerely,

cc: Reggie Mazyck, NAIC
March 26, 2021

Reggie Mazyck  
National Association of Insurance Commissioners  
1100 Walnut Street – Suite 1500  
Kansas City, MO  64106-2197

Re: APF 2020-12, CDHS

I appreciate the opportunity to provide comments on the Amendment Proposal Form 2020-12 submitted by Rachel Hemphill and Karen Jiang of the Texas Department of Insurance.

After 15 years, it would be nice if we could eliminate the CDHS concept as it was first introduced with C3-Phase II as a temporary measure until the regulators could become comfortable with the inclusion of hedge strategies that could potentially reduce capital requirements.

Since it appears the regulators are not quite ready to remove this requirement, it is important that the changes being made continue to move us closer to a principal-based approach as opposed to implementing additional regulatory restrictions and confusion as to what the valuation manual says and what is intended by the changes.

Although my preference is to remove the CDHS concept from the valuation manual, I believe the overall reason for the proposed amendment is fine. And although I generally agree conceptually with the proposal, I disagree with the changes proposed and the introduction of now another term “Seasoned Hedging Strategy”.

Theoretically, under a principle-based approach, the company should be reflecting how it is managing and how it intends to manage the assets and liabilities being modeled. This includes the investment strategy irrespective of the instruments being used. To the extent that regulators want to limit credit for certain activities, that is fine, but they need to articulate (devise rules) on what those activities are.

What does “a strategy undertaken by a company to manage risks through the future purchase or sale of hedging instruments” really mean?

So what activities constitute hedging? Can this be adequately and appropriately defined? Is the purchase of a 100-year bond as part of the company’s investment strategy also subject to CDHS requirements? Is a 100-year bond a hedging instrument? What about floating rate bonds? Would
this be exempt from a CDHS but if a fixed income bond was purchased and swapped for floating, the CDHS requirements would need to be met?

We need to remember, that CDHS was first introduced where the line between investment strategy and hedging was easier to draw because 15 years ago the strategies employed for variable annuities were distinctive and easily identified. As we move to cover more product types from fixed life and annuities to equity-indexed life and annuities to structured annuities, the distinction between investment strategy and hedging gets harder to distinguish.

For this reason, I prefer to move closer to a principle-based approach that reflects the investments the company has and anticipates to have in the future with disclosure as to the strategies employed and the risks involved.

With respect to CDHS if we retain the concept I would propose:

a. The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
b. The hedge objectives.
c. The risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
d. The financial instruments used to hedge the risks.
e. The hedge trading rules, including the permitted tolerances from hedging objectives.
f. The metrics, criteria, and frequency for measuring hedging effectiveness.
g. The criteria used to measure hedging effectiveness.
h. The frequency of measuring hedging effectiveness.
i. The conditions under which hedging will not take place.
j. The person or persons responsible for implementing the hedging strategy.
k. Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
l. The circumstances under which hedging strategy will not be effective in hedging the risks.
m. **Discussion of primary risks associated with the strategy employed.**

As to the items I propose removing; in general, I think it is hard to document infinite lists such as what risk are not hedged, conditions when hedging will not take place, and circumstances under which the hedging strategy will not be effective in hedging the risks. I do agree that as much information about the strategy should be discussed, and therefore propose discussion of the risks, but I do not believe endless lists are appropriate or should be required.

As to person or persons responsible for “implementing” the hedging strategy, do you really mean “executing” the hedging strategy? I would claim this is the company’s responsibility and the “person or persons” is irrelevant and will quickly become stale in the documentation of strategies.

Lastly, areas where basis, gap or assumption risk has been identified. For variable annuities this should all be part of documenting and quantifying CTE(Best-efforts) versus CTE(Adjusted). From VM-21, Section 9.B.4.
“Regardless of the methodology used by the company, the ultimate effect of the current hedging strategy (including currently held hedge positions) on the stochastic reserve needs to recognize all risks, associated costs, imperfections in the hedges and hedging mismatch tolerances associated with the hedging strategy. The risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, annuitization, etc.).”

I believe this alternative is conceptually consistent with the objectives of the APF. Disclosure of investment strategies and risks are required and more conservative assumptions can be used if they produce a greater reserve or capital requirement. (I.e. Disclosure of CDHS items is required to reduce requirement.) If we keep the CDHS terminology we still need to make sure we can articulate when is a strategy subject to these CDHS requirements. Is it only when we utilize hedge accounting? Is it only when derivatives (excluding mortgage derivatives) are used? Is it only when the variability of potential outcomes exceeds a specific tolerance (i.e. strategies with greater uncertainty)? However, I believe this moves us closer to a principle-based approach and therefore will be more robust and infuse less confusion in the modeling of investments and strategies for a variety of products.

Sincerely,

William H. Wilton, CFA, FSA, MAAA
1. Identify yourself, your affiliation and a very brief description (title) of the issue.

**Identification:**
Rachel Hemphill and Karen Jiang, Texas Department of Insurance

**Title of the Issue:**
Create consistency between CDHS determination in VM-20 and VM-21. Revise hedge modeling to only require CDHS if modeling future hedging reduces the reserves under VM-20 or TAR under VM-21.

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


January 1, 2021 NAIC Valuation Manual

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

See attached.

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

**Summary of 4/2/2021 Updates:**

1. Revisions were made to VM-20 Section 7.K.4 (add “supporting the policies”) and VM-21 Section 9.A.6 (add “supporting the contracts”) in response to Nationwide’s comments.

2. We added a definition for “hedging transactions,” taken from the APPM but modified slightly to be consistent with Valuation Manual terminology in response to Will Wilton’s comments.

3. We have updated the list of CDHS criteria in response to Will Wilton’s comments where we agreed:
   a. Added “significant” before risks in item (c) of the CDHS definition.
   b. Combined items (f) – (h) in the CDHS definition.
   c. Change “person or persons” to “group or area, including whether internal or external,” in item (j) of the CDHS definition.
   d. We did not remove items (k) or (l) as suggested by Will Wilton, as we find this information useful to regulators. Given that these are retained, and because we were uncertain what else would be included in the new “primary risks” item suggested by Will Wilton, we have not added it. If we can be provided additional information on the risks to be reflected under this new item, an edit could be made.

4. We modified the definition of a SHS to clarify “normally modelled” in response to the ACLI comment and clarify what may be a SHS in response to Will Wilton’s comment (e.g., a single bond would not be a SHS).
We propose having consistent requirements for a CDHS in VM-20 and VM-21, as well as any future work on VM-22, and consolidating these requirements in the VM-01 definition of a CDHS. This involves adding two criteria to VM-21’s definition of CDHS that currently exist for VM-20:

- Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
- The circumstances under which hedging strategy will not be effective in hedging the risks.

These criteria are both reasonable and apply in principle to VM-21, and to any future work on VM-22, as well as VM-20.

Further, we propose revising the requirement for hedging to be a CDHS in order for future hedging to be modeled under VM-20, VM-21, and LR027’s C-3 RBC Amount calculation to only apply when modeling such hedging reduces the life reserve level or variable annuity Total Asset Requirement (TAR) level.

The current regulatory requirements for hedging to be a CDHS in order for future hedging to be modeled under VM-20, modeled under VM-21, modeled for the C-3 RBC Amount calculation for variable annuities, and to be eligible for SSAP 108 treatment are all logical requirements when one considers whether hedging should be allowed to reduce the life reserve level or variable annuity TAR level, or whether any mismatch between movements in hedge assets and movements in the corresponding reserve levels should be allowed to be amortized over time.

However, this same requirement has led to a situation of there being unintended optionality in whether a hedging strategy that is like a CDHS is modeled or is not modeled, since a company may choose to satisfy or not satisfy certain of the criteria. This has been especially relevant for cases where modeling a company’s hedging strategy would increase reserves or variable annuity TAR.

As noted in the current guidance note in VM-20 Section 7.K.1 in the 2021 Valuation Manual:

“The prohibition in these modeled reserve requirements against projecting future hedging transactions other than those associated with a clearly defined hedging strategy is intended to address initial concerns expressed by various parties that reserves could be unduly reduced by reflection of programs whose future execution and performance may have greater uncertainty. The prohibition appears, however, to be in conflict with Principle 2 listed in VM-21. Companies may actually execute and reflect in their risk assessment and evaluation processes hedging strategies similar in many ways to clearly defined hedging strategies but lack sufficient clarity in one or more of the qualification criteria. By excluding the associated derivative instruments, the investment strategy that is modeled may also not reflect the investment strategy the company actually uses. Further, because the future hedging transactions may be a net cost to the company in some scenarios and a net benefit in other scenarios, the exclusion of such transactions can result in a modeled reserve that is either lower or higher than it would have been if the transactions were not excluded. The direction of such impact on the reserves could also change from period to period as the actual and projected paths of economic conditions change. A more graded approach to recognition of non-qualifying hedging strategies may be more theoretically consistent with Principle 2. It is recommended that as greater experience is gained by actuaries and state insurance regulators with the principle-based approach and as industry hedging programs mature, the various requirements of this section be reviewed.”

We propose to continue addressing the regulatory concern that reserves could be unduly reduced by reflection of programs whose future execution and performance may have greater uncertainty, by continuing to only allowing hedging strategies that qualify as a CDHS to reduce life reserves and variable annuity TAR. However, we propose that the treatment of CDHS be made more principles-based and less
subject to manipulation. To accomplish this, the proposal requires that any hedging strategy that is a part of the investment strategy supporting the policies and is normally modeled as part of the company's risk assessment and evaluation processes be modeled as if it were a CDHS if doing so results in an increase in life reserves or variable annuity TAR.

That is, CDHS becomes a requirement solely for hedging strategies that reduce life reserves or variable annuity TAR, and so becomes a more clear regulatory guardrail requiring that hedging strategies that reduce life reserves or variable annuity TAR must be clearly defined.

We continue to need the concept of a CDHS. A CDHS simply formally documents items that a company should be able to document for a robust, well-defined hedging strategy. It requires that the following be identified:

a. The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
b. The hedge objectives.
c. The risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
d. The financial instruments used to hedge the risks.
e. The hedge trading rules, including the permitted tolerances from hedging objectives.
f. The metrics for measuring hedging effectiveness.
g. The criteria used to measure hedging effectiveness.
h. The frequency of measuring hedging effectiveness.
i. The conditions under which hedging will not take place.
j. The person or persons responsible for implementing the hedging strategy.
k. Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
l. The circumstances under which hedging strategy will not be effective in hedging the risks.

While the last two criteria have historically applied for life but not variable annuities, these are all reasonable documentation items that for a robust, well-defined hedging strategy regardless of whether the product is life or variable annuity.

The concept of a CDHS is used for accounting in SSAP 108. SSAP 108 allows companies to set up a deferred asset or liability to amortize the mismatch between changes in the value of the liability and changes in the value of the hedging instruments attributable to the hedged risk underlying a highly effective CDHS modeled for VM-21. Allowing this treatment encourages companies to reduce risk through robust, well-defined and highly effective hedging. Without having the hedging strategy be well-defined, regulators could not rely on past effectiveness being indicative of future effectiveness, and so could not offer companies the benefit of SSAP 108 treatment. Once we recognize the need for a concept of a well-defined hedging strategy, the only question is what criteria would need to be met to be considered well-defined – that is, what criteria should be required to be considered a CDHS. This is a distinct question from whether the concept of a CDHS is needed. We have not heard critiques of individual criteria in the CDHS definition, but consideration of the criteria is appropriate as we go forward to make the definitions in VM-20 and VM-21 consistent. Similarly, in reserve and capital calculations, we rely on the concept of historical effectiveness to determine an error factor. If modeling hedging reduces the reserve or capital amount, the error factor determines the magnitude to which this is reflected. However, this use of the historical effectiveness relies on the hedging strategy being well-documented and comparable between historical hedging and planned future hedging. So, again, a need for hedging strategies to be well-defined presents itself – a CDHS concept is needed.

Finally, edits to VM-31 are needed to reflect these updates and bring VM-20 and VM-21 reporting requirements more in line with one another where appropriate.

Note on Coordination with RBC and APPM: We have reviewed, and with these edits there are no corresponding edits necessary for LR027 for RBC but corresponding edits are necessary for SSAP 108. A referral to SAPWG is to be concurrently considered with this APF.
The term “clearly defined hedging strategy” (CDHS) means a strategy undertaken by a company to manage risks through the future purchase or sale of hedging instruments and the opening and closing of hedging positions. A CDHS must identify:

a. The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
b. The hedge objectives.
c. The insignificant risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
d. The financial instruments used to hedge the risks.
e. The hedge trading rules, including the permitted tolerances from hedging objectives.
f. The metrics, criteria, and frequency for measuring hedging effectiveness.
g. The conditions under which hedging will not take place.
h. The group or area, including whether internal or external, responsible for implementing the hedging strategy.
i. Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
j. The circumstances under which hedging strategy will not be effective in hedging the risks.

The hedge strategy may be dynamic, static, or a combination thereof. A strategy involving the offsetting of the risks associated with products falling under the scope of different requirements within the Valuation Manual (e.g., VM-20, VM-21, or VM-22) does not qualify as CDHS. A CDHS must meet all of the principles outlined in VM-21 Section 1.B (the most relevant of which may be Principle 5).

Guidance Note: For purposes of the above criteria, “effectiveness” need not be measured in a manner as defined in SSAP No. 86—Derivatives in the AP&P Manual.

The term “hedging transaction” means a derivative(s) transaction which is entered into and maintained to reduce:

a. The risk of a change in the fair value or cash flow of assets and liabilities which the company has acquired or incurred or has a firm commitment to acquire or incur or for which the company has a forecasted acquisition or incurrence; or
b. The currency exchange rate risk or the degree of foreign currency exposure in assets and liabilities which the company has acquired or incurred or has a firm commitment to acquire or incur or for which the company has forecasted acquisition or incurrence;

The term “Seasoned Hedging Strategy” (SHS) means a hedging strategy that is part of the company’s investment strategy and for which future hedging transactions are normally modeled as part of the company’s risk assessment and evaluation process. A SHS may or may not be a CDHS.

A strategy involving the offsetting of the risks associated with products falling under the scope of different requirements within the Valuation Manual (e.g., VM-20, VM-21, or VM-22) does not qualify as SHS. A SHS must meet all of the principles outlined in VM-21 Section 1.B (the most relevant of which may be Principle 5).
VM-20 Section 6.A.1.b

A company may not exclude a group of policies for which there is one or more CDHS or one or more SHS required to be modeled pursuant to Section 7.K.4 from stochastic reserve requirements, except in the case where all CDHS and all SHS required to be modeled pursuant to Section 7.K.4 are solely associated with product features that are determined to not be material under Section 7.B.1 due to low utilization.

VM-20 Section 7.E.1.g

Notwithstanding the above requirements, the modeled reserve shall be the higher of that produced by the model investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the model investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (A2/A).

Policy loans, equities and derivative instruments associated with the execution of a CDHS (in compliance with the definition of CDHS in VM-01) or a SHS that is required to be modeled pursuant to Section 7.K.4 are not affected by this requirement.

VM-20 Section 7.K

K. Modeling of Derivative Programs

1. When determining the deterministic reserve and the stochastic reserve, the company shall include in the projections the appropriate costs and benefits of derivative instruments that are currently held by the company in support of the policies subject to these requirements. The company shall also include the appropriate costs and benefits of anticipated future derivative instrument transactions associated with the execution of a CDHS or a SHS that is required to be modeled pursuant to Section 7.K.4, as well as the appropriate costs and benefits of anticipated future derivative instrument transactions associated with non-hedging derivative programs (e.g., replication, income generation) undertaken as part of the investment strategy supporting the policies, provided they are normally modeled as part of the company’s risk assessment and evaluation processes.

2. For each derivative program that is modeled, the company shall reflect the company’s established investment policy and procedures for that program; project expected program performance along each scenario; and recognize all benefits, residual risks and associated frictional costs. The residual risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, etc.). Frictional costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. For CDHS or SHS required to be modeled pursuant to Section 7.K.4, the company may not assume that residual risks and frictional costs have a value of zero, unless the company demonstrates in the PBR Actuarial Report that “zero” is an appropriate expectation.

3. In circumstances where one or more material risk factors related to a derivative program are not fully captured within the cash-flow model used to calculate CTE 70, the company shall reflect such risk factors by increasing the stochastic reserve as described in Section 5.E.

4. If a SHS supporting the policies is not a CDHS but modeling it would result in an increase to the company’s minimum reserve, then the company shall model the SHS as if it were a CDHS when calculating reserves under VM-20.

Commented [RH8]: Added “supporting the policies” in response to Nationwide comments.
VM-20 Section 7.L (Remove entire Section 7.L)

A clearly defined hedging strategy must identify:

- The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
- The hedge objectives.
- The risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
- The financial instruments used to hedge the risks.
- The hedge trading rules, including the permitted tolerances from hedging objectives.
- The metrics for measuring hedging effectiveness.
- The criteria used to measure hedging effectiveness.
- The frequency of measuring hedging effectiveness.
- The person or persons responsible for implementing the hedging strategy.
- Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
- The circumstances under which hedging strategy will not be effective in hedging the risks.

Hedging strategies involving the offsetting of the risks associated with other products outside of the scope of these requirements is not a clearly defined hedging strategy.

Guidance Note: For purposes of the above criteria, “effectiveness” need not be measured in a manner as defined in SSAP No. 86—Derivatives in the AP&P Manual.
VM-21 Section 1.D.2 (Delete entire definition and renumber subsequent sections VM-21 Section 1.D.3 and VM-21 Section 1.D.4)

VM-21 Section 4.A.4

Modeling of Hedges

a. For a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6:

   i. The company shall not consider the cash flows from any future hedge purchases or any rebalancing of existing hedge assets in its modeling.

   ii. Existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets. The hedge assets may then be considered in one of two ways:

      a) Include the asset cash flows from any contractual payments and maturity values in the projection model; or

      b) No hedge positions – in which case the hedge positions held on the valuation date are replaced with cash and/or other general account assets in an amount equal to the aggregate market value of these hedge positions.

Guidance Note: If the hedge positions held on the valuation date are replaced with cash, then as with any other cash, such amounts may then be invested following the company’s investment strategy.

A company may switch from method a) to method b) at any time, but it may only change from b) to a) with the approval of the domiciliary commissioner.

b. For a company with a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6, the detailed requirements for the modeling of hedges are defined in Section 9. The following paragraphs are a high-level summary and do not supersede the detailed requirements.

   i. The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the projections used in the determination of the stochastic reserve.

   ii. The projections shall take into account the appropriate costs and benefits of hedge positions expected to be held in the future through the execution of the CDHS or the SHS that is required to be modeled pursuant to Section 9.A.6. Because models do not always accurately portray the results of hedge programs, the company shall, through back-testing and other means, assess the accuracy of the hedge modeling. The company shall determine a stochastic reserve as the weighted average of two CTE values; first, a CTE70 (“best efforts”) representing the company’s projection of all of the hedge cash flows, including future hedge purchases, and a second CTE70 (“adjusted”) which shall use only hedge assets held by the company on the valuation date and no future hedge purchases. These are discussed in greater detail in Section 9. The stochastic reserve shall be the weighted average of the two CTE70 values, where the weights reflect the error factor (E) determined following the guidance of Section 9.C.4.

   iii. The company is responsible for verifying compliance with CDHS requirements, or SHS requirements if required to be modeled pursuant to Section 9.A.6, and any other requirements in Section 9 for all hedging instruments included in the projections.
iv. The use of products not falling under the scope of these requirements (e.g., equity-indexed annuities) as a hedge shall not be recognized in the determination of accumulated deficiencies.

VM-21 Section 4.D.4.b

Notwithstanding the above requirements, the model investment strategy and any non-prescribed asset spreads shall be adjusted as necessary so that the aggregate reserve is not less than that which would be obtained by substituting an alternative investment strategy in which all fixed income reinvestment assets are public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a CDHS (in compliance with the definition of CDHS in VM-01) or a SHS that is required to be modeled pursuant to Section 9.A.6 are not affected by this requirement.

VM-21 Section 6.B.3.a.ii – Footnote (Footnote at Bottom of Page 21-22)

Throughout this Section 6, references to CTE70 (adjusted) shall also mean the Stochastic Reserve for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6 as discussed in Section 4.A.4.a.

 VM-21 Section 6.B.3.b.ii

Calculate the Prescribed Projections Amount as the CTE70 (adjusted) using the same method as that outlined in Section 9.C (which is the same as the stochastic reserves following Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6) but substituting the assumptions prescribed by Section 6.C. The calculation of this Prescribed Projections Amount also requires that the scenario reserve for any given scenario be equal to or in excess of the cash surrender value in aggregate on the valuation date for the group of contracts modeled in the projection.

VM-21 Section 6.B.5

Cash flows associated with hedging shall be projected in the same manner as that used in the calculation of the CTE70 (adjusted) as discussed in Section 9.C or Section 4.A.4.a for a company without a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6.

VM-21 Section 9

Section 9: Modeling of Hedges under a CDHS

A. Initial Considerations

1. Subject to Section 9.C.2, the appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the calculation of the stochastic reserve, determined in accordance with Section 3.D and Section 4.D.

2. If the company is following a CDHS, in accordance with an investment policy adopted by the board of directors, or a committee of board members, the company shall take into account the costs and benefits of hedge positions expected to be held by the company in the future along each scenario based on the execution of the hedging strategy, and it is eligible to reduce the amount of the stochastic reserve using projections.
otherwise calculated. The investment policy must clearly articulate the company’s hedging objectives, including the metrics that drive rebalancing/trading. This specification could include maximum tolerable values for investment losses, earnings, volatility, exposure, etc. in either absolute or relative terms over one or more investment horizons vis-à-vis the chance of occurrence. Company management is responsible for developing, documenting, executing and evaluating the investment strategy, including the hedging strategy, used to implement the investment policy.

3. For this purpose, the investment assets refer to all the assets, including derivatives supporting covered products and guarantees. This also is referred to as the investment portfolio. The investment strategy is the set of all asset holdings at all points in time in all scenarios. The hedging portfolio, which also is referred to as the hedging assets, is a subset of the investment assets. The hedging strategy is the hedging asset holdings at all points in time in all scenarios. There is no attempt to distinguish what is the hedging portfolio and what is the investment portfolio in this section. Nor is the distinction between investment strategy and hedging strategy formally made here. Where necessary to give effect to the intent of this section, the requirements applicable to the hedging portfolio or the hedging strategy are to apply to the overall investment portfolio and investment strategy.

4. This particularly applies to restrictions on the reasonableness or acceptability of the models that make up the stochastic cash-flow model used to perform the projections, since these restrictions are inherently restrictions on the joint modeling of the hedging and non-hedging portfolio. To give effect to these requirements, they must apply to the overall investment strategy and investment portfolio.

5. Before either a new or revised hedging strategy can be used to reduce the amount of the stochastic reserve otherwise calculated, the hedging strategy should be in place (i.e., effectively implemented by the company) for at least three months. The company may meet the time requirement by having evaluated the effective implementation of the hedging strategy for at least three months without actually having executed the trades indicated by the hedging strategy (e.g., mock testing or by having effectively implemented the strategy with similar annuity products for at least three months).

6. If a SHS supporting the contracts is not a CDHS but modeling it as if it were a CDHS would result in an increase in the company’s TAR, then the company shall model the SHS as if it were a CDHS when calculating reserves under AG43 and/or VM-21 and when calculating the C-3 RBC Amount under LR027. The company shall not treat the SHS as a CDHS for purposes of SSAP 108.

B. Modeling Approaches

1. The analysis of the impact of the hedging strategy on cash flows is typically performed using either one of two types of methods as described below. Although a hedging strategy normally would be expected to reduce risk provisions, the nature of the hedging strategy and the costs to implement the strategy may result in an increase in the amount of the stochastic reserve otherwise calculated.

2. The fundamental characteristic of the first type of method, referred to as the “explicit method,” is that hedging positions and their resulting cash flows are included in the stochastic cash-flow model used to determine the scenario reserve, as discussed in Section 3.D, for each scenario.

3. The fundamental characteristic of the second type of method, referred to as the “implicit method,” is that the effectiveness of the current hedging strategy on future cash flows is evaluated, in part or in whole, outside of the stochastic cash-flow model. There are multiple ways that this type of modeling can be implemented. In this case, the reduction to the stochastic reserve otherwise calculated should be commensurate with the degree of effectiveness of the hedging strategy in reducing accumulated deficiencies otherwise calculated.

4. Regardless of the methodology used by the company, the ultimate effect of the current hedging strategy (including currently held hedge positions) on the stochastic reserve needs to recognize all risks, associated costs, imperfections in the hedges and hedging mismatch tolerances associated with the hedging strategy.
The risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, annuitization, etc.). Costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. In addition, the reduction to the stochastic reserve attributable to the hedging strategy may need to be limited due to the uncertainty associated with the company’s ability to implement the hedging strategy in a timely and effective manner. The level of operational uncertainty varies indirectly with the amount of time that the new or revised strategy has been in effect or mock tested.

Guidance Note: No hedging strategy is perfect. A given hedging strategy may eliminate or reduce some but not all risks, transform some risks into others, introduce new risks, or have other imperfections. For example, a delta-only hedging strategy does not adequately hedge the risks measured by the “Greeks” other than delta. Another example is that financial indices underlying typical hedging instruments typically do not perform exactly like the separate account funds, and hence the use of hedging instruments has the potential for introducing basis risk.

A safe harbor approach is permitted for CDHS reflection for those companies whose modeled hedge assets comprise only linear instruments not sensitive to implied volatility. For companies with option-based hedge strategies, electing this approach would require representing the option-based portion of the strategy as a delta-rho two-Greek hedge program. The normally modeled option portfolio would be replaced with a set of linear instruments that have the same first-order Greeks as the original option portfolio.

C. Calculation of Stochastic Reserve (Reported)

1. The company shall calculate CTE70 (best efforts)—the results obtained when the CTE70 is based on incorporating the CDHS (including both currently held and future hedge positions) into the stochastic cash-flow model on a best efforts basis, including all of the factors and assumptions needed to execute the CDHS (e.g., stochastic implied volatility). The determination of CTE70 (best efforts) may utilize either explicit or implicit modeling techniques.

2. The company shall calculate a CTE70 (adjusted) by recalculating the CTE70 assuming the company has no CDHS, therefore following the requirements of Section 4.A.4.a.

3. Because most models will include at least some approximations or idealistic assumptions, CTE70 (best efforts) may overstate the impact of the hedging strategy. To compensate for potential overstatement of the impact of the hedging strategy, the value for the stochastic reserve is given by:

\[
\text{Stochastic reserve} = \text{CTE70 (best efforts)} + E \times \max[0, \text{CTE70 (adjusted)} – \text{CTE70 (best efforts)}]
\]

4. The company shall specify a value for E (the “error factor”) in the range from 5% to 100% to reflect the company’s view of the potential error resulting from the level of sophistication of the stochastic cash-flow model and its ability to properly reflect the parameters of the hedging strategy (i.e., the Greeks being covered by the strategy), as well as the associated costs, risks and benefits. The greater the ability of the stochastic model to capture all risks and uncertainties, the lower the value of E. The value of E may be as low as 5% only if the model used to determine the CTE70 (best efforts) effectively reflects all of the parameters used in the hedging strategy. If certain economic risks are not hedged, yet the model does not generate scenarios that sufficiently capture those risks, E must be in the higher end of the range, reflecting the greater likelihood of error. Likewise, simplistic hedge cash-flow models shall assume a higher likelihood of error.

5. The company shall conduct a formal back-test, based on an analysis of at least the most recent 12 months, to assess how well the model is able to replicate the hedging strategy in a way that supports the determination of the value used for E.

6. Such a back-test shall involve one of the following analyses:
   a. For companies that model hedge cash flows directly (“explicit method”), replace the stochastic scenarios used in calculating the CTE70 (best efforts) with a single scenario that represents the market path that actually manifested over the selected back-testing period and compare the projected hedge asset gains and
losses against the actual hedge asset gains and losses – both realized and unrealized – observed over the same time period. For this calculation, the model assumptions may be replaced with parameters that reflect actual experience during the back-testing period. In order to isolate the comparison between the modeled hedge strategy and actual hedge results for this calculation, the projected liabilities should accurately reflect the actual liabilities throughout the back-testing period; therefore, adjustments that facilitate this accuracy (e.g., reflecting actual experience instead of model assumptions, including new business, etc.) are permissible.

To support the choice of a low value of E, the company should ascertain that the projected hedge asset gains and losses are within close range of 100% (e.g., 80–125%) of the actual hedge asset gains and losses. The company may also support the choice of a low value of E by achieving a high R-squared (e.g., 0.80 or higher) when using a regression analysis technique.

b. For companies that model hedge cash flows implicitly by quantifying the cost and benefit of hedging using the fair value of the hedged item (an “implicit method” or “cost of reinsurance method”), calculate the delta, rho and vega coverage ratios in each month over the selected back-testing period in the following manner:

i. Determine the hedge asset gains and losses—both realized and unrealized—incur over the month attributable to equity, interest rate, and implied volatility movements.

ii. Determine the change in the fair value of the hedged item over the month attributable to equity, interest rate, and implied volatility movements. The hedged item should be defined in a manner that reflects the proportion of risks hedged (e.g., if a company elects to hedge 50% of a contract’s market risks, it should quantify the fair value of the hedged item as 50% of the fair value of the contract).

iii. Calculate the delta coverage ratio as the ratio between (i) and (ii) attributable to equity movements.

iv. Calculate the rho coverage ratio as the ratio between (i) and (ii) attributable to interest rate movements.

v. Calculate the vega coverage ratio as the ratio between (i) and (ii) attributable to implied volatility movements.

vi. To support the company’s choice of a low value of E, the company should be able to demonstrate that the delta and rho coverage ratios are both within close range of 100% (e.g., 80–125%) consistently across the back-testing period.

vii. In addition, the company should be able to demonstrate that the vega coverage ratio is within close range of 100% in order to use the prevailing implied volatility levels as of the valuation date in quantifying the fair value of the hedged item for the purpose of calculating CTE70 (best efforts). Otherwise, the company shall quantify the fair value of the hedged item for the purpose of calculating CTE70 (best efforts) in a manner consistent with the realized volatility of the scenarios captured in the CTE (best efforts).

c. Companies that do not model hedge cash flows explicitly, but that also do not use the implicit method as outlined in Section 9.C.6.b above, shall conduct the formal back-test in a manner that allows the company to clearly illustrate the appropriateness of the selected method for reflecting the cost and benefit of hedging, as well as the value used for E.

7. A company that does not have 12 months of experience to date shall set E to a value that reflects the amount of experience available, and the degree and nature of any change to the hedge program. For a material change in strategy, with no history, E should be at least 0.50. However, E may be lower than 0.50 if some reliable experience is available and/or if the change in strategy is a refinement rather than a substantial change in strategy.

**Guidance Note:** The following examples are provided as guidance for determining the E factor when there has been a change to the hedge program:
• The error factor should be temporarily large (e.g., \( \geq 50\% \)) for substantial changes in hedge methodology (e.g., moving from a fair-value based strategy to a stop-loss strategy) where the company has not been able to provide a meaningful simulation of hedge performance based on the new strategy.

• A temporary moderate increase (e.g., 15–30%) in error factor should be used for substantial modifications to hedge programs or CDHS modeling where meaningful simulation has not been created (e.g., adding second-order hedging, such as gamma or rate convexity).

• No increase in the error factor may be used for incremental modifications to the hedge strategy (e.g., adding death benefits to a program that previously covered only living benefits, or moving from swaps to Treasury Department futures).

D. Additional Considerations for CTE70 (best efforts)

If the company is following a CDHS, the fair value of the portfolio of contracts falling within the scope of these requirements shall be computed and compared to the CTE70 (best efforts) and CTE70 (adjusted). If the CTE70 (best efforts) is below both the fair value and CTE70 (adjusted), the company should be prepared to explain why that result is reasonable.

For the purposes of this analysis, the stochastic reserve and fair value calculations shall be done without requiring the scenario reserve for any given scenario to be equal to or in excess of the cash surrender value in aggregate for the group of contracts modeled in the projection.

E. Specific Considerations and Requirements

1. As part of the process of choosing a methodology and assumptions for estimating the future effectiveness of the current hedging strategy (including currently held hedge positions) for purposes of reducing the stochastic reserve, the company should review actual historical hedging effectiveness. The company shall evaluate the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, the mix of business and other items that are likely to result in materially adverse results. This includes an analysis of model assumptions that, when combined with the reliance on the hedging strategy, are likely to result in adverse results relative to those modeled. The parameters and assumptions shall be adjusted (based on testing contingent on the strategy used and other assumptions) to levels that fully reflect the risk based on historical ranges and foreseeable future ranges of the assumptions and parameters. If this is not possible by parameter adjustment, the model shall be modified to reflect them at either anticipated experience or adverse estimates of the parameters.

2. A discontinuous hedging strategy is a hedging strategy where the relationships between the sensitivities to equity markets and interest rates (commonly referred to as the Greeks) associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets are subject to material discontinuities. This includes, but is not limited to, a hedging strategy where material hedging assets will be obtained when the variable annuity account balances reach a predetermined level in relationship to the guarantees. Any hedging strategy, including a delta hedging strategy, can be a discontinuous hedging strategy if implementation of the strategy permits material discontinuities between the sensitivities to equity markets and interest rates associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets. There may be scenarios that are particularly costly to discontinuous hedging strategies, especially where those result in large discontinuous changes in sensitivities (Greeks) associated with the hedging assets. Where discontinuous hedging strategies contribute materially to a reduction in the stochastic reserve, the company must evaluate the interaction of future trigger definitions and the discontinuous hedging strategy, in addition to the items mentioned in the previous paragraph. This includes an analysis of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.

3. A strategy that has a strong dependence on acquiring hedging assets at specific times that depend on specific values of an index or other market indicators may not be implemented as precisely as planned.
4. The combination of elements of the stochastic cash-flow model—including the initial actual market asset prices, prices for trading at future dates, transaction costs and other assumptions—should be analyzed by the company as to whether the stochastic cash-flow model permits hedging strategies that make money in some scenarios without losing a reasonable amount in some other scenarios. This includes, but is not limited to:

a. Hedging strategies with no initial investment that never lose money in any scenario and in some scenarios make money.

b. Hedging strategies that, with a given amount of initial money, never make less than accumulation at the one-period risk-free rates in any scenario but make more than this in one or more scenarios.

5. If the stochastic cash-flow model allows for such situations, the company should be satisfied that the results do not materially rely directly or indirectly on the use of such strategies. If the results do materially rely directly or indirectly on the use of such strategies, the strategies may not be used to reduce the stochastic reserve otherwise calculated.

6. In addition to the above, the method used to determine prices of financial instruments for trading in scenarios should be compared to actual initial market prices. In addition to comparisons to initial market prices, there should be testing of the pricing models that are used to determine subsequent prices when scenarios involve trading financial instruments. This testing should consider historical relationships. For example, if a method is used where recent volatility in the scenario is one of the determinants of prices for trading in that scenario, then that model should approximate actual historic prices in similar circumstances in history.

**VM-31 Section 3.C.5**

Assets and Risk Management – A brief description of the asset portfolio, and the approach used to model risk management strategies, such as hedging, and other derivative programs, including a description of any CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4.

**VM-31 Section 3.D.6.f**

Risk Management – Detailed description of model risk management strategies, such as hedging and other derivative programs, specific to the groups of policies covered in this sub-report and not discussed in the Life Summary Section. This should include documentation for any hedging strategy that meets the requirements to be a CDHS. It should also include, for any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4, documentation of any CDHS criteria met, listing of CDHS criteria not met, and documentation of the reserve level with and without the SHS being modeled as if it were a CDHS.


a. Investment Officer on Investments – A certification from a duly authorized investment officer that the modeled company investment strategy, including any CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4, is representative of and consistent with the company’s investment policy.

b. Qualified Actuary on Investments – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4 was performed in accordance with VM-20 and in compliance with all applicable ASOPs, and the alternative investment strategy as defined in VM-20 Section 7.E.1.g reflects the prescribed mix of assets with the same WAL as the reinvestment assets in the company investment strategy.

**VM-31 Section 3.E.5**

Assets and Risk Management – A brief description of the general account asset portfolio, and the approach used to model risk management strategies, such as hedging and other derivative programs, including a description of any
VM-31 Section 3.F.8

Hedging and Risk Management – The following information regarding the hedging and risk management assumptions used by the company in performing a principle-based valuation under VM-21:

a. Strategies – Detailed description of risk management strategies, such as hedging and other derivative programs, including any CDHS or any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, specific to the groups of contracts covered in this sub-report.
   i. Descriptions of basis risk, gap risk, price risk and assumption risk.
   ii. Methods and criteria for estimating the a priori effectiveness of the strategy.
   iii. Results of any reviews of actual historical hedging effectiveness.

b. CDHS – Documentation for any hedging strategy that meets the requirements to be a CDHS.

c. Other Modeled Hedging Strategies – Documentation for any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, including documentation of any CDHS criteria met, listing of CDHS criteria not met, and documentation of the TAR level with and without the SHS being modeled as if it were a CDHS.

d. Strategy Changes – Discussion of any changes to the hedging strategy during the past 12 months, including identification of the change, reasons for the change, and the implementation date of the change.

e. Hedge Modeling – Description of how the hedge strategy was incorporated into modeling, including:
   i. Differences in timing between model and actual strategy implementation.
   ii. For a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, disclosure of the method used to consider hedge assets included in the starting assets, either (1) including the asset cash flows in the projection model; or (2) replacing the hedge positions with cash and/or other general account assets in an amount equal to the market value of the hedge positions, as discussed in VM-21 Section 4.A.4.a.
   iii. Evaluations of the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, and other items that are likely to result in materially adverse results.
   iv. If residual risks and frictional costs are assumed to have a value of zero, a demonstration that a value of zero is an appropriate expectation.
   v. Any discontinuous hedging strategies modeled, and where such discontinuous hedging strategies contribute materially to a reduction in the stochastic reserve, any evaluations of the interaction of future trigger definitions and the discontinuous hedging strategy, including any analyses of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.
   vi. Disclosure of any situations where the modeled hedging strategies make money in some scenarios without losing a reasonable amount in some other scenarios, and an explanation of why the situations are not material for determining the CTE 70 (best efforts).
   vii. Results of any testing of the method used to determine prices of financial instruments for trading in scenarios against actuarial initial market prices, including how the testing considered historical relationships. If there are substantial discrepancies, disclosure of the substantial discrepancies and documentation as to why the model-based prices are appropriate for determining the stochastic reserve.
   viii. Any model adjustments made when calculating CTE 70 (adjusted), in particular, any liquidation or substitution of assets for currently held hedges.

e. Error Factor (E) and Back-Testing – Description of E, the error factor, and formal back-tests performed, including:
   i. The value of E, and the approach and rationale for the value of E used in the reserve calculation.
ii. For companies that model hedge cash flows using the explicit method, as described in VM-21 Section 9.C.6.a, and have 12 months of experience, an analysis of at least the most recent 12 months of experience and the results of a back-test showing that the model is able to replicate the hedging results experienced in a way that justifies the value used for $E$. Include at least a ratio of the actual change in market value of the hedges to the modeled change in market value of the hedges at least quarterly.

iii. For companies that model hedge cash flows using the implicit method, and have 12 months of experience, as described in VM-21 Section 9.C.6.b, the results of a back-test in which (a) actual hedge asset gains and losses are compared against (b) proportional fair value movements in hedged liability, including:
   a) Delta, rho and vega coverage ratios in each month over the back-testing period, which may be presented in a chart or graph.
   b) The implied volatility level used to quantify the fair value of the hedged item, as well as the methodology undertaken to determine the appropriate level used.

iv. For companies that do not model hedge cash flows using either the explicit method or the implicit method, as described in VM-21 Section 9.C.6.c, and have 12 months of experience, the results of the formal back-test conducted to validate the appropriateness of the selected method and value used for $E$.

v. For companies that do not have 12 months of experience, the basis for the value of $E$ is chosen based on the guidance provided in VM-21 Section 9.C.7, considering the actual history available and the degree and nature of any changes made to the hedge strategy.

f. Safe Harbor for CDHS – If electing the safe harbor approach for CDHS, as discussed in VM-21 Section 9.C.8, a description of the linear instruments used to model the option portfolio.

g. Hedge Model Results – Disclosure of whether the calculated CTE 70 (best efforts) is below both the fair value and CTE 70 (adjusted), and if so, justification for why that result is reasonable, as discussed in VM-21 Section 9.D.

**VM-31 Section 3.F.12.c**

CTEPA – If using the CTEPA method, a summary including:

i. Disclosure (in tabular form) of the scenario reserves using the same method and assumptions as those used by the company to calculate CTE 70 (adjusted) as outlined in VM-21 Section 9.C (or the stochastic reserves following VM-21 Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6), as well as the corresponding scenarios reserves substituting the assumptions prescribed by VM-21 Section 6.C.

ii. Summary of results from a cumulative decrement projection along the scenario whose reserve value is closest to the CTE 70 (adjusted), as outlined in VM-21 Section 9.C (or the stochastic reserves following VM-21 Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6), under the assumptions outlined in VM-21 Section 6.C. Such a cumulative decrement projection shall include, at the end of each projection year, the projected proportion (expressed as a percent of the total projected account value) of persisting contracts as well as the allocation of projected decrements across death, full surrender, account value depletion, elective annuitization, and other benefit election.

iii. Summary of results from a cumulative decrement projection, identical to (ii) above, but replacing all assumptions outlined in VM-21 Section 6.C with the corresponding assumptions used in calculating the stochastic reserve.

**VM-31 Section 3.F.16.a and Section 3.F.16.b**

a. **Investment Officer on Investments** – A certification from a duly authorized investment officer that the modeled asset investment strategy, including any CDHS and any SHS that is required to be modeled pursuant
to VM-21 Section 9.A.6., is consistent with the company’s current investment strategy except where the modeled reinvestment strategy may have been substituted with the alternative investment strategy, and also any CDHS meets the requirements of a CDHS.

b. **Qualified Actuary on Investments** – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any CDHS and any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6 was performed in accordance with VM-21 and in compliance with all applicable ASOPs.

*Deleted: clearly defined hedging strategies*
Mortality Data Collection: Upcoming Events

Pat Allison, FSA, MAAA
April 8, 2021

2021 Experience Data Collection Timeline

Now
Companies may: 1) request exemptions or communicate exclusions (ongoing until 9/30/21), 2) review training materials, and 3) prepare submissions

Q2, 2021
Call for companies to submit data for 2018 and 2019 observation years using 2020/2021 Valuation Manual requirements. As of 4/1/21, we are expecting to collect data from 127 companies, representing approximately 90% of industry claims.

9/30/21
Deadline to submit data using the Regulatory Data Collection (RDC) tool. Automatic feedback on form and format data exceptions will be provided upon submission. Additional feedback will be provided within 30 days based on actuarial review.

12/31/21
Deadline for companies to make corrections

5/31/22
NAIC to submit aggregate experience data to SOA
Topics for Future Meetings with Companies

- Kick-off Meeting: Overview of data collection process, resources, and steps companies need to take prior to the data call
- Data validation and reasonability checks the NAIC will perform
- Walk-through of sample control total and reconciliation templates
- Communications with companies
- Policy for data submission by a reinsurer or third-party administrator
- How to submit data using the RDC Tool
HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee April 12, 2021, Minutes ................................................................. 7-2
Consumer Information (B) Subgroup April 1, 2021, Minutes (Attachment One) ................................................................. 7-6
Health Innovations (B) Working Group March 26, 2021, Minutes (Attachment Two) .......................................................... 7-8
The Health Insurance and Managed Care (B) Committee met April 12, 2021. The following Committee members participated: Jon Godfread, Chair (ND); Jessica K. Altman, Vice Chair (PA); Lori K. Wing-Heier (AK); Michael Conway (CO); Dean L. Cameron (ID); Kathleen A. Birранe (MD); Anita G. Fox (MI); Grace Arnold (MN); Russell Toal (NM); Glen Mulready (OK); Andrew R. Stolfi (OR); Jonathan T. Pike (UT); Mike Kreidler represented by Molly Nollette (WA); and James A. Dodrill (WV). Also participating were: Jim L. Ridling (AL); Ricardo Lara (CA); David Altmaier (FL); Doug Ommen (IA); Dana Popish Severinghaus (IL); Vicki Schmidt (KS); Sharon P. Clark (KY); Eric A. Cioppa (ME); Mike Chaney (MS); Mariano A. Mier Romeu (PR); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Mark Afable (WI); and Jeff Rude (WY).

1. Heard a Presentation from the Biden Administration on its Federal Legislative and Administrative Initiatives and Priorities

Jeff Wu (federal Centers for Medicare & Medicaid Services—CMS) updated the Committee on the Biden Administration’s legislative and administrative priorities. He discussed the history of health insurance marketplaces with respect to the number of uninsured, enrollment and insurer participation. He said there was a sharp decrease in the uninsured after 2010, followed by an increase since 2016. He also pointed out that minority rates of the uninsured were persistently higher in 2019 than for whites. He discussed the effects of the COVID-19 pandemic on the number of uninsured. He explained that the Biden Administration’s initial fears of increases in the uninsured was driven by the high unemployment rate during the beginning months of the COVID-19 pandemic. However, he noted that pre-pandemic research suggests that the federal Affordable Care Act (ACA) plays a critical role in helping people maintain coverage after job losses, which may have mitigated coverage changes due to unemployment. In addition, he said the uninsured rate did not increase dramatically because many individuals who lost some form of employment had low incomes or were in jobs without health benefits, and some were either enrolled in Medicaid or were already uninsured before their job loss. He said economic relief and other COVID-19 measures provided in the federal Families First Coronavirus Response Act (FFCRA) and the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act were contributing factors in stabilizing the number of uninsured.

Mr. Wu said enrollment in the health insurance marketplaces has steadied over time and insurer participation in the marketplaces has improved, but premium cost remains a challenge. He discussed how provisions in the federal American Rescue Plan Act of 2021 (ARPA) could address some of the marketplace premium cost issues. President Biden signed the ARPA into law on March 11. He said the ARPA makes major improvements in access to and affordability of health coverage through the marketplace by increasing eligibility for financial assistance to help pay for marketplace coverage. The ARPA also lowers premiums for most people who currently have a marketplace health plan and expands access to financial assistance for more consumers because of the increased tax credits to reduce their premiums. Mr. Wu also described other provisions in the ARPA, including: 1) subsidies to cover 100% of the cost of premiums for Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage; and 2) funding for grants to states to assist state-based marketplaces (SBMs) with implementation, covering information technology (IT) changes, and outreach.

Mr. Wu provided an update on the number of individuals who have enrolled to date in the marketplaces using the current special enrollment period (SEP), which has been extended to Aug. 31. He discussed the Biden Administration’s National Consumer Outreach Campaign to increase awareness among the uninsured about the existence of the SEP and the affordability and availability of assistance to pay for premiums. He announced that the CMS is making approximately $2.3 million in additional funding available to current navigator grantees in federally facilitated marketplace (FFM) states to support the outreach, education and enrollment efforts around the 2021 SEP.

Mr. Wu briefly discussed the federal No Surprises Act (NSA) and provisions in the NSA that provide consumer protections regarding surprise bills. He also touched on the Biden Administration’s efforts to address the COVID-19 pandemic through provisions in the FFCRA, the CARES Act, and other policy initiatives, including releasing additional guidance and toolkits on COVID-19 vaccine and testing coverage.

Commissioner Altman asked Mr. Wu about any initiatives the CMS might be pursuing to address the gap in the number of uninsured among minority groups versus the number of uninsured among whites and whether there would be opportunities for the NAIC to partner with the CMS to address the issue. She also asked how the CMS plans to coordinate with SBMs if it is working on this issue. Mr. Wu acknowledged the issue of health equity in health insurance coverage. He explained that one way the Biden Administration is working to initially address this gap is through significant investment in the navigator program.
Commissioner Godfread said state insurance regulators have reached out to the CMS for clarification on how the ARPA and reinsurance programs that states have implemented through the ACA’s Section 1332 waiver program are to work together with respect to pass through payment calculations moving forward. Mr. Wu said the CMS is aware of this issue and is working to provide answers on this issue to the states soon.

2. **Adopted its 2020 Fall National Meeting Minutes**

Superintendent Toal made a motion, seconded by Director Cameron, to adopt the Committee’s Dec. 7, 2020, minutes (see *NAIC Proceedings – Fall 2020, Health Insurance and Managed Care (B) Committee*). The motion passed unanimously.

3. **Adopted its Subgroup, Working Group and Task Force Reports**

Commissioner Conway made a motion, seconded by Director Cameron, to adopt the following reports: the Consumer Information (B) Subgroup, including its April 1 minutes (Attachment One); the Health Innovations (B) Working Group, including its March 26 minutes (Attachment Two); the Health Actuarial (B) Task Force, including its 2021 revised charges; and the Senior Issues (B) Task Force.

3. **Adopted the Regulatory Framework (B) Task Force Report and Received the Draft PBM Model Act**

Commissioner Conway said the Regulatory Framework (B) Task Force met March 25 and took the following action: 1) adopted its March 18, March 1, and 2020 Fall National Meeting minutes; 2) received an update from Georgetown University’s Center on Health Insurance Reforms (CHIR) on its work related to the ACA and two recently enacted federal laws; i.e., the NSA and the ARPA; 3) heard a presentation on the NSA; and 4) heard a discussion of the recent U.S. Supreme Court decision in Rutledge vs. Pharmaceutical Care Management Association (PCMA).

Commissioner Conway said the Task Force met March 18 and adopted the draft NAIC [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model). He said after an almost year-long drafting process, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adopted the proposed new NAIC model in late October 2020, completing its charge to “consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs)” and “consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.” During its meeting at the 2020 Fall National Meeting, the Task Force deferred immediate adoption of the draft PBM model and exposed it for an additional public comment period ending Dec. 22, 2020.

Commissioner Conway said the Task Force discussed the comments received on the draft PBM model during its March 1 meeting and adopted it during its March 18 meeting with non-substantive changes based on the comments received. He explained that at its core, the draft PBM model is a PBM licensing model. He said after a lot of discussion and given the lack of national consensus on some issues, particularly issues related to PBM pricing and cost transparency, the Subgroup decided on this framework. As a compromise, to address those topics that it felt there was not a national consensus to include in the substantive provisions of the draft PBM model, Commissioner Conway said the Subgroup decided to add a drafting note to Section 8—Regulations. The drafting note includes state statutory citations for 15 topic areas involving certain PBM business practices that some states might want to consider when developing their state legislation regulating PBMs.

Commissioner Conway said there has been a lot of debate and discussion, including during the Task Force’s March 18 meeting, on the appropriateness of including such options in an NAIC model, given the potential for the lack of uniform adoption by the states. However, the Task Force decided to move forward with adoption and forward the draft PBM model to the Committee for its consideration and additional discussion, as the Committee deems appropriate. Commissioner Conway explained that during its March 18 meeting, the Task Force discussed and decided to move forward with developing a new 2021 charge directing the Subgroup to develop a white paper to further detail state options in regulating PBM business practices with respect to some of the 15 topic areas included in the proposed Section 8 drafting note. He said the white paper also is to touch on how the Rutledge vs. Pharmaceutical Care Management Association (PCMA) decision may or may not affect state options in this area.

Director Cameron made a motion, seconded by Director Wing-Heier, to adopt the Regulatory Framework (B) Task Force’s report. The motion did not include adoption of the draft PBM model. After discussion, the Committee decided to defer adoption of the draft PBM model until it could further discuss the issues Commissioner Conway highlighted in his report, particularly the issues related to the Section 8 drafting note. The Committee will meet sometime after the Spring National Meeting to continue the discussion.
5. Received an Update on the Special (EX) Committee on Race and Insurance Workstream Five’s Work

Commissioner Altman and Commissioner Lara, co-chairs of the Special (EX) Committee on Race and Insurance (Special Committee) Workstream Five, provided an update to the Committee on Workstream Five’s work to date. Commissioner Lara said since the Special Committee created Workstream Five last year, the Workstream has been meeting in open and regulator-to-regulator sessions to work on its charge to “examine and to determine which practices or barriers exist in the insurance sector that potentially disadvantage people color and/or historically underrepresented groups in the health insurance line of business” and “make recommendations on action steps.” He said one of the first actions the Workstream took was to meet Dec. 2, 2020, to hear from various stakeholders to help the Workstream members identify and understand more fully disparities in health insurance affecting racial and historically underrepresented groups and what questions the Workstream members should be asking themselves and considering as it moves forward.

Commissioner Lara said the testimony provided during that Dec. 2, 2020, meeting confirmed the Workstream’s initial thoughts that access to care and network adequacy is an ongoing and persistent issue for people of color and/or historically underrepresented population groups. She said Workstream Five also believes the other issues it has identified merit discussion and examination as well, including affordability.

Commissioner Altman said as reported during the Special Committee’s meeting April 12, following its Dec. 2, 2020, meeting, Workstream Five met in regulator-to-regulator sessions to develop and finalize its initial report and recommendations to the Special Committee for its consideration. She said the Special Committee discussed 2021 proposed charges that included Workstream Five’s recommendations included in its initial report and exposed them for a 30-day public comment period ending May 14.

Commissioner Altman said the 2021 proposed charges include charges to the Committee and two of its groups; i.e., the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group and the Health Innovations (B) Working Group. She said the 2021 proposed charges also direct Workstream Five to continue its work in various areas the Workstream identified in its initial report as areas for more discussion, including network adequacy and consumer education.

Commissioner Altman said as the Workstream moves forward with its work related to network adequacy, the Workstream plans to focus its research on measures to remedy impacts on historically marginalized groups, as well as examination of the use of network adequacy and provider directory measures to promote equitable access to culturally competent care. She said as the Workstream continues its work related to consumer education targeted toward people of color and/or historically underrepresented population groups, Workstream Five plans to monitor opportunities and identify strategies for consumer education to address equity issues. The Workstream will make referrals, as appropriate, to the Consumer Information (B) Subgroup to develop educational materials after identifying areas and strategies believed to help increase awareness in communities of color and among other underrepresented groups.

Commissioner Altman said during the NAIC/Consumer Liaison Committee’s April 8 meeting, there were two presentations that reflected core areas Workstream Five is discussing with respect to health equity and communities of color and/or historically underrepresented groups; i.e., maternal health outcomes and coverage for children. She said the Workstream plans to continue to act as a forum for discussion of these issues as it continues its work.

6. Heard a Discussion on the 2021 Work of the Committee’s Subgroup, Working Group and Task Forces

Jolie H. Matthews (NAIC) discussed the 2021 work of the Committee’s subgroup, working group and task forces. She said included in the Committee meeting materials is a document that summarizes the 2021 charges for each of the groups that report to the Committee. The document also lists each group’s chair and, as appropriate, vice chair and NAIC staff support.

Ms. Matthews highlighted a few of the additional projects some of the groups, including the Committee itself, most likely will have to take on in addition to the work in their 2021 ongoing charges. She said the Consumer Information (B) Subgroup most likely will be tasked with preparing new consumer-facing materials related to health equity and diversity based on recommendations from Workstream Five. She said the Subgroup also anticipates completing additional work related to the NSA and the ARPA as it discussed during its April 1 meeting.

Ms. Matthews said the Health Innovations (B) Working Group will continue its work to gather and share information, best practices, experience and data to inform and support health innovation at the state and national levels with respect to the ACA and other health policy initiatives. She said over the last year, in part, because of the COVID-19 pandemic and how the federal
government and the states have used telehealth to address issues with access, the Working Group has been focusing on telehealth issues. She said based on a new 2021 charge from the Special Committee, as recommended by Workstream Five, it is anticipated that the Working Group will continue its focus on telehealth, but with respect to health equity and diversity issues.

Ms. Matthews said the Health Actuarial (B) Task Force will continue its work related to the ACA; but in addition to that work, the Task Force could take on additional work related to recently enacted federal legislation, such as the NSA and the ARPA. She said the Task Force recently submitted its recommendations to the CMS for the definition of “Geographic Regions” in the NSA.

Ms. Matthews said the Regulatory Framework (B) Task Force will continue to supervise the work of its working groups and subgroups. She said as Commissioner Conway discussed during this report to the Committee, the Task Force will be meeting soon to finalize a new charge for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup for it to begin work on a white paper that will discuss options for the states to regulate certain PBM business practices and the effect, if any, the decision the Rutledge vs. Pharmaceutical Care Management Association (PCMA) case may have on those options. She said the Employee Retirement Income Security Act (ERISA) (B) Working Group is also anticipated to meet to discuss the Rutledge vs. Pharmaceutical Care Management Association (PCMA) decision from the ERISA preemption perspective and consider revising the Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation (ERISA Handbook), as appropriate, to include a discussion of the case. The MHPAEA (B) Working Group will begin work related to its anticipated new charge from the Special Committee to examine health equity and diversity in the mental health and substance use disorder (MH/SUD) treatment context during a meeting on April 21.

Ms. Matthews said the Senior Issues (B) Task Force will continue its core mission to examine issues affecting older Americans. She said like last year, it is anticipated that the Task Force will focus on long-term care insurance (LTCI) issues. The Task Force established a new subgroup, the Long-Term Care Insurance Model Update (B) Subgroup, to review the existing NAIC LTCI models to determine if any changes need to be made. She said that in addition to this work, the Subgroup will also consider any additional changes to these models as a result of the Long-Term Care Insurance (EX) Task Force’s discussions.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met April 1, 2021. The following Subgroup members participated: Mary Kwei, Chair, Joy Hatchett, and Paul Meyer (MD); Debra Judy, Vice Chair (CO); Anthony Williams (AL); Randy Pipal and Weston Trexler (ID); Michelle Baldock (IL); LeAnn Crow, Brenda Johnson, and Craig Van Aalst (KS); Judith Watters (ME); Carrie Couch, Jo LeDuc, and Michelle Vickers (MO); Kathy Shortt (NC); Laura Arp and Martin Swanson (NE); Cuc Nguyen and Mike Rhoads (OK); Katie Dzurec and Lars Thorne (PA); Candy Holbrook and Jill Kruger (SD); David Combs, Brian Hoffmeister, Jennifer Ramcharan, and Vickie Trice (TN); Heidi Clausen, Shelley Wiseman, and Jaakob Sundberg (UT); and Christina Keely and Jennifer Stegall (WI). Also participating was Emily DeLaGarza (MI).

1. **Discussed Potential Areas of Work for 2021**

Ms. Kwei said the group would work on products to help both state insurance regulators and consumers. She asked the Subgroup to consider the different topics it would like to cover during 2021, including direction from the Health Insurance and Managed Care (B) Committee to work on the federal No Surprises Act. She said some No Surprises Act topics likely fit into the group’s plan to develop a guide for consumers on the claims process.

Ms. Kwei asked whether changes to premium tax credits and COBRA subsidies are the key topics to cover from the federal American Rescue Plan. Subgroup members agreed that they are. Ms. Judy asked whether the Subgroup should work on individual coverage health reimbursement arrangements as part of its work on the American Rescue Plan, but the Subgroup concluded that it is not relevant to that law.

Eric Ellsworth (Consumers Checkbook) asked if the Subgroup would consider working on data products that could be incorporated into consumer materials, like in an app. He said consumer understanding of networks should also be considered.

Kris Hathaway (America’s Health Insurance Plans—AHIP) asked how the Subgroup would address the proposed topic of CPT codes. Ms. Kwei responded that consumers frequently encounter the codes as part of a denial, but do not understand them. She said a product could explain what a CPT code is and why they are important.

2. **Discussed the Sequencing of Work Products**

Ms. Kwei asked where materials on the claims process fit in with materials on new federal legislation. She asked whether revising the document Frequently Asked Questions on Health Care Reform should be done sooner than in past years. Ms. Arp said the FAQ responses would be useful in other materials, so either one could come first. Ms. DeLaGarza said the American Rescue Plan changes are temporary, so the full FAQ should not necessarily be updated. Subgroup members voiced support for starting with updates to the FAQ, in a separate addendum, to reflect changes made by the American Rescue Plan.

Mr. Ellsworth said exchanges will make a lot of information available to consumers about expanded tax credits, so the FAQ should incorporate existing materials. He said there is less available on the No Surprises Act.

Ms. Kwei said No Surprises Act work will need to be informed by rules expected from federal agencies over the summer, so the Subgroup should wait to develop related materials until those are available.

The Subgroup discussed the timeline for completing new questions for the FAQ addendum related to the American Rescue Plan.

Jeff Klein (McIntyre and Lemon) said the Virginia Corporation Commission recently released a helpful consumer document on health savings accounts.
Harry Ting (Consumer Representative) said the Subgroup is not reaching as many people as it should with its products. He said the Subgroup should discuss strategies for how to make more people aware of the group’s products. Sylvia Yee (Disability Rights Education and Defense Fund—DREDF) said new networks have been formed by community organizations around COVID-19 vaccination and they could be used to disseminate insurance consumer information. Mr. Ellsworth said the Subgroup should work to gather feedback on whether its products are useful and understandable for consumers.

Ms. Judy said that the Subgroup should take advantage of existing documents and mentioned one from Beyond the Basics on American Rescue Plan provisions.

The Subgroup decided that it would consider new questions for the FAQ addendum drafted by Ms. Kwei and Ms. Kruger.

Having no further business, the Consumer Information (B) Subgroup adjourned.
The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met March 26, 2021. The following Working Group members participated: Andrew R. Stolfi, Chair (OR); Laura Arp, Co-Vice Chair (NE); Nathan Houdrek, Co-Vice Chair, Barbara Belling, Diane Dambach, Darcy Paskey, Mark Prodoehl, Rebecca Rebholz and Richard Wicka (WI); Philip Barlow and Howard Liebers (DC); Angela Burke Boston, Andria Seip and Cynthia Banks Radke (IA); Claire Szpara (IN); Craig Van Aalst, Julie Holmes and Tate Flott (KS); Robert Wake and Marti Hooper (ME); Renee Campbell and Karen Dennis (MI); Grace Arnold, Helen Bassett, Galen Benshoof and Peter Brickwedde (MN); Camille Anderson-Weddle, Carrie Couch, Chlora Lindley-Myers, Jo LeDuc and Amy Hoyt (MO); Chrystal Bartuska, Angie Voegele and Karri Volk (ND); Michelle Heaton and Maureen Belanger (NH); Christine Machnowsky (NJ); Paige Duhamel (NV); Mark Garett (NV); Jessica K. Altman and Katie Dzurec (PA); Doug Danzeiser, Essi Eargle, R. Michael Markham, Ryan Jaffe, Debra Diaz-Lara and Angelica Garza (TX); Shelly Wiseman, Tanji Northrup and Jaakob Sundberg (UT); Jane Beyer, Jennifer Kreitler and Molly Nollette (WA); and Joylynn Fix (WV).

1. Heard Presentations on Regulations Regarding Coverage for Telehealth Services

Mei Wa Kwong (Center for Connected Health Policy—CCHP) gave a presentation on recent activity by the federal government and states to regulate coverage for telehealth services. She described changes made to allow and encourage greater use of telehealth in Medicare, Medicaid and by private payers. She identified state trends in 2021, including activity related to mental health and substance use disorder services, allowing telephone-only connections, requirements on regulatory boards to consider telehealth, and discussions on what to make permanent. She shared resources available from CCHP that continue to track changes in telehealth policy.

Commissioner Stolfi asked about lists of state legislative activity. Ms. Kwong said the CCHP website has a section devoted to state COVID-19 responses, as well an annual legislative roundup. Commissioner Stolfi asked what states might see from the federal level going forward. Ms. Kwong said federal programs have significant influence, but they are in the same position of a lot of states, deciding which changes to make permanent. She said her expectation is that some but not all of the federal telehealth changes will be extended.

Tim Clement (American Psychiatric Association—APA) provided a presentation on the use of telehealth by psychiatrists. He noted the sharp increase in telehealth services provided during the pandemic and shared study results that he said indicate the quality of telehealth services matches that of in-person services. He said the APA has supported state insurance regulators’ efforts to expand access to telehealth. He said even though APA members strongly prefer in-person services, they recognize some patients prefer or need telehealth services, both during the pandemic and after. He cited the APA’s model legislation on telehealth, which requires payment parity, allows telephone-only connections in limited circumstances, and prohibits insurers from employing utilization review that is not used for in-person services. He noted that physicians’ overhead costs are not lower because of telehealth unless they completely shut down their offices and only offer telehealth. He said the APA is open to payment parity requirements that might require a provider to maintain an office location.

Dr. Drew Oliveira (Regence BlueShield) presented on his plan’s experience with telehealth, as well as virtual and digital care. He said telehealth had previously been focused on urgent care visits and provider-to-provider consultations in rural areas. He said the majority of patients who used telehealth during the pandemic would do so again, and about 20% prefer virtual over in-person services. He said up to half of primary care and 85% of behavioral health care could potentially be delivered virtually. He described digital and in-home care as treatment methods in addition to synchronous telecommunication. He gave examples of physical therapy visits and orthopedic exams as new types of care that are starting to be delivered by telehealth. He said telehealth can support better access to care in rural and underserved areas, but it may require audio-only services until gaps in broadband access can be closed. He said he worries about fragmentation in care due to telehealth and said information sharing is important. He said there is also some worry about high-frequency, low-value care—like texting back and forth—that may not be beneficial. He said payment parity can perpetuate fee for service payments, and it would be helpful to put telehealth into a prospective payment system. He said a federal Health Insurance Portability and Accessibility Act (HIPAA)-compliant system would be preferable to audio-only, but it may take a while to get there.
Commissioner Stolfi asked whether there is any difference in effectiveness in telehealth for first visits and also about health equity. Mr. Clement said studies he is aware of did not break out first versus subsequent visits. He said research shows telehealth can increase access to underserved communities and that more research is ongoing.

Dr. Oliveira said behavioral health services have been underused in the past and that telehealth can encourage more appropriate use. Ms. Kwong said there has been a lack of studies on the impact of telehealth on communities of color. She said impacts are likely to vary from place to place.

Mr. Houdek asked how the payment parity issue has worked in other states and what state insurance regulators should think about. Mr. Clement said alternative payment models should be developed specifically for telehealth and that providers are willing to compromise on pure payment parity. Ms. Kwong said quality levels are comparable and questioned whether lower payments for telehealth would discourage its use after the pandemic. She said telehealth utilization dropped as states opened up. Dr. Oliveira said Medicare’s relative value calculation took overhead costs into account, and they should be considered with telehealth going forward, but closer to 80% of in-person costs than one-third. He said some telehealth visits are replacements for in-person, and others are in addition.

Commissioner Stolfi asked how health plan thinking about telehealth has shifted due to the pandemic. Dr. Oliveira said access to trained practitioners needs to be expanded. He said there can be cost savings if a practitioner can monitor someone who gets better faster because they complete physical therapy at home rather than waiting for an office visit. He said the biggest concern is connecting back to the practitioners who are providing care in person.

2. Discussed State Responses to the COVID-19 Pandemic

Commissioner Stolfi asked state insurance regulators how they have innovated and changed how they do business in the last 13 months due to the pandemic. Ms. Nollette and Ms. Kreitler responded for Washington. They described how the provider network access program responded to a proposal from an issuer to offer a product with a telemedicine-only network tier. Ms. Kreitler described the questions state insurance regulators asked the carrier and said the network was approved when the carrier agreed to the same cost-sharing for the telemedicine-only tier and the second tier of in-person providers.

Commissioner Stolfi asked about the scope of Washington’s provider contract reviews and the staff resources devoted to it. Ms. Kreitler said four staff members work on the reviews for about 8,000 contracts per year, and it takes approximately two hours per contract. Contracts are reviewed for the protection of the enrollee, including hold harmless, clean claim and grievance provisions.

Ms. Arp said Nebraska received many complaints from the behavioral health community regarding telehealth near the beginning of the pandemic. The state surveyed carriers on their policies and posted the answers on its website.

The Working Group discussed payment parity laws in their states.

3. Discussed Other Matters

Commissioner Arnold raised the impacts of increased premium tax credits on state reinsurance programs run with Section 1332 waivers. She said Minnesota and other states with reinsurance programs sent a letter to the federal Centers for Medicare & Medicaid Services (CMS) asking it to revise the pass through amounts it will pay states for 2021. She said insurers’ rates have already been set, but tax credits are changing, so the federal government will save more and should recalculate to share savings with states. She said there are other complex issues for 2022, but the letter was focused on 2021. Commissioner Stolfi asked how much movement there could be and whether states might adjust their reinsurance parameters. Commissioner Arnold said Minnesota is likely at the high end of how much additional funds it would receive because it has a lower percentage of subsidized enrollees compared to other states. She said states will likely have to provide additional information to CMS to justify revised amounts.

Wayne Turner (National Health Law Program—NHeLP) pointed out two resources for the Working Group. One was an article in Health Affairs on disproportionately low use of telehealth by patients with limited English proficiency. The second was a set of principles from a consortium of citizens with disabilities on how best to serve persons with disabilities with telehealth.
Kris Hathaway (America’s Health Insurance Plans—AHIP) noted that AHIP and the Blue Cross and Blue Shield Association (BCBSA) have initiated a vaccine community connector program to enhance vaccinations among vulnerable groups. She said state insurance regulators with questions could reach out to her or to the BCBSA through Randi Chapman or Clay McClure.

Having no further business, the Health Innovations (B) Working Group adjourned.
HEALTH ACTUARIAL (B) TASK FORCE

The Health Actuarial (B) Task Force did not meet at the Spring National Meeting.
REGULATORY FRAMEWORK (B) TASK FORCE

Regulatory Framework (B) Task Force March 25, 2021, Minutes.................................................................7-13
  Regulatory Framework (B) Task Force March 18, 2021, Minutes (Attachment One).................................7-16
    Pharmacy Benefit Manager (PBM) Model Draft Dated March 12, 2021 (Attachment One-A).............7-18
  Regulatory Framework (B) Task Force March 1, 2021, Minutes (Attachment Two).................................7-24
  Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group Jan. 28, 2021, Minutes
    (Attachment Three) ..................................................................................................................................7-28
The Regulatory Framework (B) Task Force met March 25, 2021. The following Task Force members participated: Michael Conway, Chair (CO); Bruce R. Ramge, Vice Chair (NE); Lori K. Wing-Heier (AK); Jim L. Ridling represented by Jennifer Li and Yada Horace (AL); Peni Itula Sapini Teo represented by Elizabeth Perri (AS); Evan G. Daniels represented by Sterling Gavette (AZ); Ricardo Lara represented by Bruce Hinze (CA); Andrew N. Mais represented by Jared Kosky (CT); Karima M. Woods represented Howard Liebers (DC); David Altmairer represented by Chris Struk (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron (ID); Dana Popish Severingham represented by Shannon Whalen and Eric Anderson (IL); Stephen W. Robertson represented by Claire Szpara (IN); Vicki Schmidt represented by Tate Flott, Julie Holmes, Chris Hollenbeck and Shannon Lloyd (KS); Sharon P. Clark (KY); Gary D. Anderson represented by Rebecca Butler (MA); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox represented by Sarah Wohlford and Karen Dennis (MI); Grace Arnold represented by Peter Brickwedde (MN); Chlora Lindley-Myers represented by Amy Hoyt and Camille Anderson-Weddle (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread (ND); Chris Nicolopoulos represented by Michelle Heaton (NH); Marlene Caride represented by Chanell McDevitt (NJ); Judith L. French (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Larry D. Deiter (SD); Doug Slape represented by Rachel Bowden, Richard Lunsford and Doug Danzeiser (TX); Jonathan T. Pike represented by Tanji J. Northrup and Jaakob Sundberg (UT); Scott A. White represented by Don Beatty (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Nathan Houdek and Jennifer Stegall (WI); and James A. Dodrill (WV).

1. **Adopted its March 18, 2021; March 1, 2021; and 2020 Fall National Meeting Minutes**

The Task Force met March 18, 2021; March 1, 2021; and Nov. 19, 2020. During these meetings, the Task Force discussed comments received on the draft the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM Model Act) and adopted the PBM Model Act.

Ms. Nollette made a motion, seconded by Commissioner Deiter, to adopt the Task Force’s March 18, 2021 (Attachment One), March 1, 2021 (Attachment Two); and Nov. 19, 2020 (see NAIC Proceedings – Fall 2020, Regulatory Framework (B) Task Force) minutes. The motion passed unanimously.

2. **Adopted its Subgroup and Working Group Reports**

Ms. Nollette made a motion, seconded by Commissioner Deiter, to adopt the following reports: the Accident and Sickness Insurance Minimum Standards (B) Subgroup; the Employee Retirement Income Security Act (ERISA) (B) Working Group; the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its Jan. 28 minutes (Attachment Three); and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup. The motion passed unanimously.

3. **Heard an Update on the CHIR’s Work Related to the ACA**

Justin Giovannelli (Center on Health Insurance Reforms—CHIR, Georgetown University Health Policy Institute) provided an update on the CHIR’s work related to the federal Affordable Care Act (ACA) and recently enacted federal laws such as the federal No Surprises Act (NSA) and the federal American Rescue Plan Act (ARPA) and other issues of interest to state insurance regulators. He discussed the CHIR’s efforts to assess the impact of the extended special enrollment periods (SEPs) into the federal health insurance exchanges, as provided in the ARPA, on access and affordability of coverage and how it will be implemented. The CHIR is particularly interested in assessing the impact of these provisions on the individual market given that some are temporary. He also discussed the CHIR’s work related to the federal and state implementation of the NSA.

Mr. Giovannelli said the CHIR is also looking at the issue of the “family glitch” and potential solutions. The “family glitch” is the ACA rule that bases eligibility for a family’s premium subsidies on whether available employer-sponsored insurance is affordable for the employee only, even if it is not actually affordable for the whole family. The CHIR is continuing its work to track state regulatory reforms affecting the individual market, such as the ACA’s Section 1332 waiver program, including whether the states are looking at other options, in addition to reinsurance programs, considering the ARPA and other Biden administration changes, that could positively affect the affordability of comprehensive coverage. The CHIR anticipates publishing an issue brief on this topic soon.
Mr. Giovannelli also discussed some of the CHIR’s upcoming work on network adequacy and standardized health plans and noncomprehensive coverage arrangements. He said the CHIR is continuing its work of tracking state regulatory approaches to the COVID-19 pandemic. Additionally, Mr. Giovannelli highlighted the CHIR’s ongoing state technical assistance regarding insurance regulatory matters with the support of the Robert Wood Johnson Foundation (RWJF) through its State Health and Value Strategies Program and the support of the Laura and John Arnold Foundation (LJAF).

Commissioner Conway asked Mr. Giovannelli if the CHIR, as part of its work it plans to do with respect to noncomprehensive plans and health care sharing ministries, would be examining its appeal to consumers considering the ARPA and its new provisions enhancing the affordability of comprehensive coverage in the individual market. Mr. Giovannelli said the CHIR would be looking at this as part of its study.

4. Heard a Presentation on the NSA

Jack Hoadley (Georgetown University Health Policy Institute) presented on the NSA. He discussed the NSA’s scope, including what types of plans it covers and where its protections apply. The NSA does not apply to short-term plans and excepted benefits plans. It also does not apply to ground ambulance services, but it does apply to air ambulance services. Mr. Hoadley also described how the NSA protects patients from balance bills by requiring that patients be held responsible for in-network cost sharing only and barring providers from sending or collecting a bill for amounts other than in-network cost sharing.

Mr. Hoadley also discussed a key component of the NSA—determining the payment amount for out-of-network care when there is a payment dispute. He discussed how the payment amount would be determined: 1) for states with a “specified state law” that includes a method for determining the payment, the state method applies for the health plans regulated by the state and for the services to which the state law applies; and 2) for other states or for plans not regulated by the state (self-funded plans), the federal method applies. The state method is likely to apply in the 18 states with comprehensive surprise billing laws and in several states with partial protections for applicable services.

Mr. Hoadley explained that with respect to air ambulance services, consumers are protected from balance billing similar to the NSA’s consumer protections for emergency services. The federal independent dispute resolution (IDR) system would apply. The NSA includes no protections for ground ambulance services, but it does include a provision establishing an Advisory Committee on Ground Ambulances and Patient Billing (Advisory Committee) that will make recommendations for the states and the U.S. Congress on addressing balance billing issues for such services.

Mr. Hoadley described the NSA’s enforcement mechanisms and the role that the states will have in enforcement. The state departments of insurance (DOIs) are the primary enforcers of provisions that apply to insurers and fully insured group health plans. The federal government is the enforcer in the states that fail to substantially enforce the law and for self-funded group health plans. He discussed how the NSA’s provisions will be enforced on health care providers. He explained that the states may enforce provisions on providers, including air ambulances, but the federal government will do so where a state fails to substantially enforce the law. He noted that unless addressed through federal rule-making, the NSA is silent on which state agency is responsible for enforcing provider provisions. Given that state DOIs typically do not have jurisdiction over providers, the states that have current balance billing laws have taken various approaches regarding provider enforcement, such as vesting that authority in the state DOI, health department, medical licensing entity or the state attorney general’s office. Other states have taken a blended approach by allowing the state DOI or provider licensing entity to report patterns of unresolved or intentional violations to another entity for enforcement. Mr. Hoadley also discussed how, in some cases, determining the primary enforcer—federal or state—could be challenging, which is why the states need to begin communicating with the federal agencies charged with implementing the NSA to try to address and avoid these situations.

Mr. Hoadley discussed what questions remain with the NSA with respect to states that currently have balance billing laws and those that do not. He also identified specific opportunities and questions for the states to engage with the federal agencies implementing the NSA to obtain clarification on outstanding issues prior to federal rulemaking. Additionally, he discussed next steps regarding the NSA, including the timeline for anticipated federal regulations.

Commissioner Conway asked Mr. Hoadley if he had any thoughts on why the NSA does not address ground ambulance services. Commissioner Conway said Colorado does have provisions concerning ground ambulance services, but it was a struggle for Colorado to find the right balance in crafting its provisions. Mr. Hoadley said Colorado’s experience in trying to address the ground ambulance services issues is reflective of possibly why the U.S. Congress could not reach agreement on provisions to include in the NSA on ground ambulance services. He said another issue is that ground ambulance services typically involve local county and city governments, which adds to the complexity of the issue. As such, the U.S. Congress punted the issue to the Advisory Committee.
Commissioner Conway asked about the NSA’s enforcement provisions related to health care providers. Mr. Hoadley explained that the NSA makes the states the primary enforcers regarding providers with a federal backstop if a state fails to substantially enforce the NSA’s provisions on providers. He said states that currently have balance billing laws have discovered the importance of educating providers on the front end about their laws’ provisions rather than waiting for a violation. He said the Health Policy Institute has been talking to the states to learn more about their experiences on this issue and hopes to learn more.

5. **Heard a Discussion of the Decision in Rutledge v. PCMA**

Katie Keith (Out2Enroll) discussed the recent U.S. Supreme Court’s decision in *Rutledge v. the Pharmaceutical Care Management Association (PCMA)* and its potential effect on the ability of state insurance regulators to regulate certain pharmacy benefit manager (PBM) business practices. Among the roles PBMs play in the provision of prescription drugs, PBMs act as intermediaries between pharmacies and prescription drug plans. In that role, PBMs reimburse pharmacies for the cost of drugs covered by prescription drug plans. To determine the reimbursement rate for each drug, PBMs develop and administer maximum allowable cost (MAC) lists.

Ms. Keith said that in 2015, Arkansas passed Act 900. The Arkansas law effectively requires PBMs to reimburse Arkansas pharmacies at a price equal to or higher than the pharmacy’s wholesale cost. To accomplish this result, Act 900: 1) requires PBMs to timely update their MAC lists when drug wholesale prices increase; 2) provides pharmacies an administrative appeal procedure to challenge MAC reimbursement rates; and 3) allows pharmacies to decline to sell a prescription drug if PBM reimbursement is below acquisition costs. The PCMA sued in the Eastern District of Arkansas, arguing that Act 900 is preempted under ERISA. Following a precedent set in a case, *Pharmaceutical Care Mgmt. Assn. v. Gerhart*, 852 F. 3d 722 (2017), involving a similar Iowa statute, the District Court held that ERISA preempts Act 900, and the U.S. Court of Appeals for the Eighth Circuit affirmed that decision. Ms. Keith said the U.S. Supreme Court granted writ of certiorari in the case, held oral arguments Oct. 6, 2020, and issued its decision Dec. 10, 2020. She said that in a unanimous decision written by Associate Justice Sonia Sotomayor and concurrence by Associate Justice Clarence Thomas, the Court held that Act 900 is not preempted by ERISA. Ms. Keith said this decision most likely opens up a whole range of options for those states considering PBM regulation.

Ms. Keith explained the Court’s analysis. She also summarized some of the standards from previous Court decisions related to ERISA preemption and how the Court in this case most likely weighed whether Act 900 was more like the *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) case, which the Court found concerned rate regulation that only affects the costs of ERISA plans, or the *Gobeille v. Liberty Mutual Insurance Company*, 136 S. Ct. 936 (2016) case.

Ms. Keith said the Court found Act 900 is more like the *Travelers* case. Act 900 is “merely a form of cost regulation” by requiring PBMs to reimburse pharmacies at a certain level that does not bear an impermissible connection with or reference to ERISA. The Court reasoned that “ERISA does not preempt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage.” Act 900: 1) does not “refer to” ERISA; 2) does not apply “immediately and exclusively” to ERISA plans; and 3) its application to ERISA plans is not “essential to the law’s operation.” Ms. Keith said the Court also held that Act 900 does not directly regulate health plans at all and applies to PBMs whether they act pursuant to an ERISA plan or not.

Ms. Keith said the Court rejected the PCMA’s argument that Act 900’s enforcement mechanisms directly affect central matters of plan administration and interfere with nationally uniform plan administration. The Court said Act 900’s enforcement mechanisms do not require plan administrators to structure their benefit plans in a particular way: 1) Act 900 “simply establishes a floor for the cost of benefits that plans choose to provide;” 2) ERISA does not preempt state laws that merely increase costs even if plans decide to limit benefits or charge higher rates as a result; and 3) PCMA’s position would preempt any state laws that could affect the price or provision of benefits.

Ms. Keith reiterated that she believes the *Rutledge* decision has big implications for the states with respect to PBM regulation, particularly on cost containment and the direct regulation of health care costs. She noted, however, that states are still not going to be able to regulate ERISA plans, but to the extent states are looking at hospitals and other actors in the health care system, the *Rutledge* case provides opportunities. She also said she anticipates more litigation related to these issues. Commissioner Conway said he anticipates more discussion of the *Rutledge* case as part of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s future work to develop a white paper on state options with respect to regulating PBM business practices and the ERISA (B) Working Group’s discussion of the case’s potential impact with respect to ERISA preemption.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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The Regulatory Framework (B) Task Force met March 18, 2021. The following Task Force members participated: Michael Conway, Chair (CO); Bruce R. Ramge, Vice Chair, represented by Laura Arp and Martin Swanson (NE); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by Anthony L. Williams, Jimmy Gunn and Yada Horace (AL); Evan G. Daniels represented by Jon Savary and Erin Klug (AZ); Ricardo Lara represented by Bruce Hinze and Sheirin Ghoddoucy (CA); Andrew M. Mais represented by Jared Kosky (CT); Karima M. Woods (DC); David Altmaier represented by Chris Struk (FL); Doug Ommen represented by Andria Seip, Sonya Sellmeyer and Cynthia Banks Radke (IA); Dean L. Cameron (ID); Dana Popish Severinghaus represented by Shannon Whalen (IL); Stephen W. Robertson represented by Claire Szpara (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Gary D. Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox represented by Chad Arnold, Sarah Wohlford and Renee Campbell (MI); Grace Arnold represented by Galen Benshoof and Candance Gergen (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Chris Nicolopoulos represented by Michelle Heaton and Jason Dexter (NH); Marlene Caride represented by Philip Gennace (NJ); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn and Mike Rhoads (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Larry D. Deiter (SD); Doug Slape represented by Rachel Bowden (TX); Jonathan T. Pike represented by Tanji J. Northrup and Jakob Sundberg (UT); Scott A. White represented by Don Beatty, Stephen Hogge, Bob Grissom and James Young (VA); Mike Keidler represented by Molly Nollette (WA); Mark Afable represented by Nathan Houdek, Richard Wicka and Jennifer Stegall (WI); and James A. Dodrill represented by Ellen Potter (WV).

1. Adopted the PBM Model Act

Commissioner Conway said that during the Task Force’s March 1 meeting, the Task Force heard from various stakeholders who had submitted comments on the draft [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model). He explained that following that meeting, NAIC staff had revised the draft PBM model to add additional relevant state statutory citations suggested in the some of the comment letters. He asked the Task Force members if anyone had any suggestions for additional revisions.

Commissioner Schmidt asked if Commissioner Conway had considered adding a reference to the Rutledge v. Pharmaceutical Care Management Association (PCMA) case in the Section 8—Regulations drafting note. Commissioner Conway said he asked NAIC staff if such references are typically included in NAIC models. He said NAIC staff said such language is not typically included. He also said that he anticipates more litigation involving state pharmacy benefit manager (PBM) regulation and because U.S. Supreme Court (Court) decisions tend to evolve over time, including a reference to this case could possibly be misleading in the future because stakeholders could be led to believe that the Rutledge case is the only relevant case when the Court could issue future decisions on the subject. Commissioner Conway also reiterated his support for further discussion of the Rutledge decision, but he suggested that the better setting for such a discussion would be in the proposed white paper, which the Task Force discussed charging the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup with developing during its March 1 meeting.

Commissioner Stolfi made a motion, seconded by Mr. Hinze, to adopt the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (Attachment One-A). The motion passed, with Connecticut and North Dakota voting against the motion.

Commissioner Conway asked NAIC staff about the Task Force’s next steps to charge the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup with developing the white paper as has been discussed. Jolie H. Matthews (NAIC) said the Task Force will need to develop and adopt a new 2021 Subgroup charge prior to the Subgroup beginning its work. She said the Health Insurance and Managed Care (B) Committee also would have to adopt the charge.

Mr. Kosky explained that Connecticut voted against the motion because of concerns with the Section 8 drafting note’s menu of options. He said Connecticut was concerned that the language in the drafting note could lead to inconsistency and the lack of uniformity in state adoption of the NAIC model. He said this potential lack of uniformity and standardization of language would appear to go against the NAIC’s goal when adopting NAIC models. He also expressed concern about setting a precedent. Mr. Kosky expressed support for developing a white paper and the white paper as the more appropriate vehicle to describe state options concerning PBM regulation rather than an NAIC model. Commissioner Conway said he believes some states will
add provisions beyond the PBM model’s core licensing provisions, but he believes the PBM model is a good work product with substantive core provisions that will be helpful to the states. He acknowledged that there is probably more work to be done on the menu of options in the Section 8 drafting note and that there will probably be discussion on whether the menu of options should remain in the NAIC model or be made part of the white paper.

Commissioner Schmidt noted that many state legislatures are moving forward with legislation to license or register PBMs with or without a NAIC model. She said there most likely will be no uniformity among the states as things are currently advancing in the states. She also noted how rapidly things are changing with respect to the state regulation of PBMs. She also agreed with Commissioner Conway that the Rutledge decision most likely will not be the last U.S. Supreme Court decision affecting the state regulation of PBMs, but she said she believes the PBM model is the best effort at this time.

Commissioner Altman said Pennsylvania voted in favor of the motion to move the discussion forward on the PBM model to the Health Insurance and Managed Care (B) Committee, but she also has concerns similar to Connecticut’s concerns about the Section 8 drafting note and its menu of options. She said she does not know how Pennsylvania will vote on the PBM model moving forward, but Pennsylvania strongly supports developing the white paper. Commissioner Conway acknowledged her comments. He said he agrees that the Section 8 drafting note will be a point of discussion as the PBM model moves forward, particularly because the Task Force has agreed to move forward with the white paper.

Having no further business, the Regulatory Framework (B) Task Force adjourned.
A new model

[STATE] PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

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Section 1. Short Title

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

Section 2. Purpose

A. This Act establishes the standards and criteria for the licensure and regulation of pharmacy benefit managers providing claims processing services or other prescription drug or device services for health benefit plans.

B. The purpose of this Act is to:

(1) Promote, preserve, and protect the public health, safety and welfare through effective regulation and licensure of pharmacy benefit managers;

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

(3) Provide for powers and duties of the commissioner; and

(4) Prescribe penalties and fines for violations of this Act.

Section 3. Definitions

For purposes of this Act:

A. “Claims processing services” means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:

(1) Receiving payments for pharmacist services;

(2) Making payments to pharmacists or pharmacies for pharmacist services; or

(3) Both paragraphs (1) and (2).
B. “Commissioner” means the insurance commissioner of this state.

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

C. “Covered person” means a member, policyholder, subscriber, enrollee, beneficiary, dependent or other individual participating in a health benefit plan.

D. “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.

E. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

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

F. “Other prescription drug or device services” means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including, but not limited to:

   1. Negotiating rebates, discounts or other financial incentives and arrangements with drug companies;
   2. Disbursing or distributing rebates;
   3. Managing or participating in incentive programs or arrangements for pharmacist services;
   4. Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;
   5. Developing and maintaining formularies;
   6. Designing prescription benefit programs; or
   7. Advertising or promoting services.

G. “Pharmacist” means an individual licensed as a pharmacist by the [state] Board of Pharmacy.

H. “Pharmacist services” means products, goods, and services or any combination of products, goods and services, provided as a part of the practice of pharmacy.

I. “Pharmacy” means the place licensed by the [state] Board of Pharmacy in which drugs, chemicals, medicines, prescriptions and poisons are compounded, dispensed or sold at retail.

J. (1) “Pharmacy benefit manager” means a person, business or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other prescription drug or device services, or both, to covered persons who are residents of this state, for health benefit plans.

   (2) “Pharmacy benefit manager” does not include:
(a) A health care facility licensed in this state;
(b) A health care professional licensed in this state;
(c) A consultant who only provides advice as to the selection or performance of a pharmacy benefit manager; or
(d) A health carrier to the extent that it performs any claims processing and other prescription drug or device services exclusively for its enrollees.

Section 4. Applicability

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

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

B. As a condition of licensure, any contract in existence on the date the pharmacy benefit manager receives its license to do business in this state shall comply with the requirements of this Act.

C. Nothing in this Act is intended or shall be construed to conflict with existing relevant federal law.

Section 5. Licensing Requirement

A. A person may not establish or operate as a pharmacy benefit manager in this state for health benefit plans without first obtaining a license from the commissioner under this Act.

B. The commissioner may adopt regulations establishing the licensing application, financial and reporting requirements for pharmacy benefit managers under this Act.

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

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

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

D. A person submitting an application for a pharmacy benefit manager license shall include with the application a non-refundable application fee of $[X].

E. The commissioner may refuse to issue or renew a license if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation or has been found to have violated the insurance laws of this state or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.

F. (1) Unless surrendered, suspended or revoked by the commissioner, a license issued under this section shall remain valid as long as the pharmacy benefit manager continues to do business in this state and remains in compliance with the provisions of this act and any applicable rules and regulations,
including the payment of an annual license renewal fee of $[X] and completion of a renewal application on a form prescribed by the commissioner.

(2) Such renewal fee and application shall be received by the commissioner on or before [x] days prior to the anniversary of the effective date of the pharmacy benefit manager’s initial or most recent license.

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

A. In any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding:

   (1) The nature of treatment, risks or alternative thereto;
   
   (2) The availability of alternate therapies, consultations, or tests;
   
   (3) The decision of utilization reviewers or similar persons to authorize or deny services;
   
   (4) The process that is used to authorize or deny healthcare services or benefits; or
   
   (5) Information on financial incentives and structures used by the insurer.

B. A pharmacy benefit manager may not prohibit a pharmacy or pharmacist from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available.

C. A pharmacy benefit manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials, provided that:

   (1) The recipient of the information represents it has the authority, to the extent provided by state or federal law, to maintain proprietary information as confidential; and
   
   (2) Prior to disclosure of information designated as confidential the pharmacist or pharmacy:

      (a) Marks as confidential any document in which the information appears; or
      
      (b) Requests confidential treatment for any oral communication of the information.

D. A pharmacy benefit manager may not terminate the contract of or penalize a pharmacist or pharmacy due to pharmacist or pharmacy:

   (1) Disclosing information about pharmacy benefit manager practices, except for information determined to be a trade secret, as determined by state law or the commissioner; or
   
   (2) Sharing any portion of the pharmacy benefit manager contract with the commissioner pursuant to a complaint or a query regarding whether the contract is in compliance with this Act.

E. (1) A pharmacy benefit manager may not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of the covered person’s cost-sharing amount under the terms of the health benefit plan or the amount the covered person would pay for the drug if the covered person were paying the cash price.
(2) Any amount paid by a covered person under paragraph (1) of this subsection shall be attributable toward any deductible or, to the extent consistent with section 2707 of the Public Health Service Act, the annual out-of-pocket maximums under the covered person’s health benefit plan.

Section 7. Enforcement

A. The commissioner shall enforce compliance with the requirements of this Act.

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

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

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

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

   (a) Considered proprietary and confidential;
   (b) Not subject to the [Freedom of Information Act] of this state;
   (c) Not subject to subpoena; and
   (d) Not subject to discovery or admissible in evidence in any private civil action.

C. The commissioner may use any document or information provided pursuant to Section 6C of this Act or Section 6D of this Act in the performance of the commissioner’s duties to determine compliance with this Act.

D. The commissioner may impose a penalty on a pharmacy benefit manager or the health carrier with which it is contracted, or both, for a violation of this Act. The penalty may not exceed [insert appropriate state penalty] per entity for each violation of this Act.

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

Section 8. Regulations

The commissioner may adopt regulations regulating pharmacy benefit managers that are not inconsistent with this Act.

Drafting Note: This Act is primarily intended to establish licensing standards for pharmacy benefit managers (PBMs). A number of states have enacted statutes or made suggestions that extend into the regulation of PBM business practices. The provisions below, which are followed by citations to state law where applicable, provide topic areas that states pursuing this Act may wish to consider in their proposed legislation:

(1) PBM network adequacy (Ark. Code 23-92-505 and Okla. Stat. 36-6961) (Also, see provisions in the Health Carrier Prescription Drug Benefit Management Model Act (#22) and the Health Benefit Plan Network Access and Adequacy Model Act (#74));


(3) Data reporting requirements under state price-gouging laws;
Section 9. Severability

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

Section 10. Effective Date

This Act shall be effective [insert date]. A person doing business in this state as a pharmacy benefit manager on or before the effective date of this Act shall have [six (6)] months following [insert date that the Act is effective] to come into compliance with the requirements of this Act.
The Regulatory Framework (B) Task Force met March 1, 2021. The following Task Force members participated: Michael Conway, Chair (CO); Bruce R. Rameg, Vice Chair, and Laura Arp (NE); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling(Al); Evan G. Daniels represented by Erin Klug (AZ); Ricardo Lara represented by Bruce Hinze and Tyler McKinney (CA); Andrew M. Mais represented by Jared Kosky (CT); David Altmaier represented by Chris Struk and Shannon Doheny (FL); Doug Oommen (IA); Dean L. Cameron represented by Kathy McGill (ID); Dana Popish Severinghaus represented by Eric Anderson and Kate Northland (IL); Stephen W. Robertson represented by Karl Knable, Alex Peck and Claire Szpara (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Gary D. Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Robert Wake (ME); Grace Arnold represented by Eric Taulby (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Angie Voegele (ND); Chris Nicolopoulos represented by Maureen Belanger (NH); Marlene Caride (NJ); Judith L. French represented by Theresa Schaefer, Laura Miller and Marjorie Ellis (OH); Glen Muleady represented by Andrew Schallhorn and Kim Bailey (OK); Andrew R. Stolfi represented by TK Keen (OR); Jessica K. Altman represented by Michael Humphreys and Katie Dzurec (PA); Larry D. Deiter represented by Jill Kruger and Candy Holbrook (SD); Doug Slape represented by Rachel Bowden and Doug Danzeiser (TX); Jonathan T. Pike (UT); Scott A. White represented by Don Beatty (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Nathan Houdek, Richard Wicka and Jennifer Steggall (WI); and James A. Dodrill represented by Joylynn Fix and Ellen Poter (WV). Also participating was: Troy Downing (MT).

1. Discussed Comments Received on the Draft PBM Model Act

Commissioner Conway said the main purpose of today’s meeting is for the Task Force to discuss the comments received on the draft [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model). He explained that the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adopted the draft PBM model late last year after an extensive, open drafting process. The Subgroup presented the draft PBM model to the Task Force for its consideration during a meeting last November. The Task Force decided to defer adoption of the model and open the model for a public comment period ending Dec. 22, 2020.

Commissioner Conway said the Task Force received seven comment letters from various stakeholders—America’s Health Insurance Plans (AHIP), the Blue Cross and Blue Shield Association (BCBSA), the Health Benefits Institute (HBI), the HIV+HEP Policy Institute, NAIC consumer representatives, the National Community Pharmacists Association (NCPA) and the Pharmaceutical Care Management Association (PCMA). He said each of the commenters have been given opportunity to provide an overview of their written comments to the Task Force. He said that at the end of this discussion, he plans to discuss the Task Force’s next steps, which most likely will involve discussion of the Section 8—Regulations drafting note and the impact, if any, of the U.S. Supreme Court’s decision in Rutledge vs. Pharmaceutical Care Management Association (PCMA) on the drafting note.

Kris Hathaway (AHIP) said AHIP supports the PBM licensing and registration requirements and the gag clause prohibition provisions in the draft PBM model. However, AHIP remains concerned with some of the provisions included within the draft PBM model, including the Section 8 drafting note and Section 6—Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices gag clause language. Ms. Hathaway said that specifically, AHIP believes provisions within the Section 8 drafting note language would significantly increase overall health care costs. She said other provisions in the drafting note are not clearly defined and appear to exceed the scope of the draft PBM model. Ms. Hathaway said that with respect to the gag clause language in Section 6, AHIP continues to encourage adoption of the federal gag clause language that was heavily debated and advanced with broad-based stakeholder support and more than 30 states have adopted rather than the language in Section 6, which has only been adopted by one state. She also said that if it is contemplated that additional work needs to be done considering the Rutledge decision, then the Employee Retirement Income Security Act (ERISA) (B) Working Group would be the more appropriate NAIC group to conduct such discussions—not the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup—because expanding the draft PBM model beyond its current language could jeopardize the hard work done to reach consensus.

Haile Dagne (BCBSA) said the BCBSA supports many of the core provisions in the draft PBM model and appreciates the Subgroup’s decision during its drafting process to move the broad language from the initial draft of Section 8B to a drafting
John Rutledge (South Carolina Department of Insurance) expressed concern in the provision of prescription drug benefits, including any potential changes. He noted that the NAIC has the opportunity to develop a stronger and clearer PBM model.

The Commissioner Conway asked Ms. Howard what other areas the NAIC should consider when developing a white paper. Ms. Howard said that the white paper should focus on in addition to the drafting note suggesting states consider establishing financial standards if the state restricts DOI authority because Section 5 is intended to focus on licensing requirements—not financials or reporting stipulations; 3) modifying the language in Section 6 to mirror the federal gag clause provisions; and 4) deleting Section 6A(4) and Section 6A(5) because these provisions would allow pharmacists to disclose information to which a pharmacist would not have access and could lead to consumer confusion.

J.P. Wieske (HBI) said that although the draft PBM model is not perfect and the HBI has concerns, it supports the draft PBM model as drafted. He said the draft strikes the right balance with where most states are at this time without being divisive and allows for a lot of flexibility in its design. Mr. Wieske said that he believes the Rutledge decision has no major impact on the draft PBM model, but given its flexibility, those states that may want to explore the possibility of including similar provisions that were the subject of the Rutledge case can do so. He also said the draft PBM model reflects significant compromise from various sides of the issue including pharmacies, pharmacy benefit managers, insurers, and consumer representatives. The HBI supports the draft PBM model in the spirit of compromise.

Carl Schmid (HIV+HEP Policy Institute) discussed the role of PBMs in prescription drug access and availability using drug formularies and establishing prior authorization and other utilization management techniques. He also discussed the increasing role the HIV+HEP Policy Institute believes PBMs play in the high cost of prescription drugs in the U.S. He said the HIV+HEP Policy Institute is disappointed that the draft PBM model does not include provisions related to the second part of the Subgroup’s charge to consider PBM prescription drug pricing and cost transparency. He said that instead of adding a drafting note to Section 8 providing examples of laws passed by states that address many of the important issues involving PBMs, the HIV+HEP Policy Institute believes the Subgroup should have proposed specific language pertaining to: 1) ensuring greater transparency in the work of PBMs; 2) ensuring greater enforcement; 3) establishing that PBMs have a fiduciary relationship with health carriers; and 4) allowing PBMs to pass rebates on to consumers. Mr. Schmid said the recent Rutledge decision provides more reason for the NAIC to adopt a stronger and clearer PBM model. He also said the HIV+HEP Policy Institute suggests in its comment letter additional state citations to the Section 8 drafting note.

Anna Howard (American Cancer Society Cancer Action Network—ACS CAN), speaking on behalf of the NAIC consumer representatives, said the NAIC consumer representatives are concerned that the draft PBM model will not provide states that wish to go further in their regulation of PBMs with direction and options that may be available to them. She said the NAIC consumer representatives recommend a deeper discussion of these issues and the Subgroup’s development of a white paper to allow the NAIC to: 1) better analyze and assess the role that PBMs play in the provision of prescription drug benefits; and 2) to identify and describe emerging state regulatory approaches that curb the PBMs practices that contribute to high drug prices and insurance affordability challenges. The white paper should address the breadth of topics that were ultimately left out of the draft PBM model, including transparency and reporting requirements; fiduciary duty and other business practices provisions; and consumer cost sharing and access. Ms. Howard said the NAIC consumer representatives also suggest convening the Subgroup to discuss the implications of the Rutledge decision on the draft PBM model, including any potential changes, particularly given the draft PBM model’s limited scope. She said the NAIC consumer representatives also suggest adding additional state statutory citations to the Section 8 drafting note.

Commissioner Conway asked Ms. Howard what other areas a white paper should focus on in addition to the areas examined in the Rutledge case. Ms. Howard said the white paper should discuss the specific options and model language that states can use that might want to more extensively regulate PBMs, such as the business practices listed in the Section 8 drafting note.
Matthew Magner (NCPA) said the NCPA, and the other signatories to its comment letter, have been concerned for a while about the outsized impact PBMs have had on prescription drug benefits and patient access to pharmacy services. He said PBMs not only administer pharmacy benefits for health plans, but also some own their own pharmacies, which creates a conflict of interest that interferes with the patient-pharmacy relationship and can also raise prescription drug costs for consumers. Mr. Magner said the NCPA believes that given the decision in the Rutledge case, state legislatures will be pursuing legislation to increase PBM oversight in their states. He said the states will be looking to the NAIC’s model to determine how best to accomplish this. As such, the NCPA requests the Task Force consider its suggested amendments to the draft PBM model to better prepare the states to address PBM practices that limit patient access to community pharmacy services and increase prescription drug costs, such as provisions: 1) ensuring pharmacy or patient choice; 2) imposing a fiduciary responsibility between the PBM and the health carrier; and 3) concerning pharmacy audits. Mr. Magner said the suggested amendments reflect provisions enacted in one form or another in one or more states. He said the NCPA also recommends including a reference to the Rutledge decision in the Section 8 drafting note for the states to know where to go to obtain more information about their authority to include such provisions in their laws.

Commissioner Schmidt asked if the NCPA had any comments on the NAIC consumer representatives’ suggestion for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to develop a white paper. Mr. Magner said the NCPA supports the development of a white paper and would be happy to participate in the discussions during its development to provide a community pharmacist’s perspective on the issues the white paper will most likely discuss.

Lauren Rowley (PCMA) said the PCMA, along with a variety of interested parties, including representatives of pharmacies and consumer representatives, actively participated in the Subgroup’s work on the draft PBM model. She acknowledged the Subgroup’s work was a deliberative and thoughtful discussion of the comments received, and it worked to reach a compromise on some of the draft PBM model’s provisions. She said that while the compromises in the draft do not necessarily reflect the PCMA’s ideal public policy, it does reflect a reasonable set of compromises across all interested parties. Ms. Rowley said PBMs are not insurers and do not collect premium from beneficiaries. She outlined what services PBMs provide to insurers and consumer representatives, actively participated in the Subgroup’s work on the draft PBM model. She acknowledged the Subgroup’s work was a deliberative and thoughtful discussion of the comments received, and it worked to reach a compromise on some of the draft PBM model’s provisions. She said that while the compromises in the draft do not necessarily reflect the PCMA’s ideal public policy, it does reflect a reasonable set of compromises across all interested parties. Ms. Rowley said PBMs are not insurers and do not collect premium from beneficiaries. She outlined what services PBMs provide to insurers and deliver safe, cost-effective prescription drug benefits.

Mr. Beatty questioned why discussions of the Rutledge decision should not be discussed by the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup. Ms. Rowley said the PCMA believes the ERISA (B) Working Group’s membership includes those who are well-versed in ERISA and ERISA preemption issues. She said the Court’s decision in Rutledge did not invalidate its previous decisions related to ERISA preemption. She suggested that as such, the ERISA preemption issues should, perhaps, be looked at more broadly to discuss what the Court actually said in the decision and its implications for the states with respect to PBM regulation. Commissioner Conway suggested that there was a role for both the ERISA (B) Working Group and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup concerning any discussions of the Rutledge decision.

Mr. Keen discussed the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s drafting process, including the Subgroup’s early work to ensure everyone was equally educated on these issues before it started drafting a model. He explained that the current draft PBM model reflects the differing viewpoints from the Subgroup members with respect to PBM regulation. He said some states currently have robust PBM regulatory schemes, while other states do not currently regulate them. He said this dichotomy of state PBM regulation was evident in the Subgroup’s discussions, with some Subgroup members at the beginning of the drafting process advocating for establishing an elaborate regulatory scheme in the draft with other Subgroup members advocating for a more incremental approach. Mr. Keen said that in developing the model, given this dichotomy, the Subgroup tried to come up with a draft that would be helpful for every state. He said the Subgroup also was mindful that the states wanted an NAIC model on this topic as soon as possible because their legislatures are asking for information and some sort of general framework for regulating PBMs.

Ms. Arp expressed support for Mr. Keen’s comments. She said the Subgroup ultimately ended up with the Section 8 drafting note because of the lack of a consensus among the states on the topics described in the drafting note—not because of concerns with ERISA preemption. As such, the Rutledge decision does not mean the NAIC should restart its work on the draft PBM model. The decision means that a state can consider adding provisions in its laws related to maximum allowable cost (MAC) pricing and not be vulnerable to ERISA preemption. Ms. Arp discussed the uncertainty of other provisions listed in the drafting note on the cost of prescription drugs and the importance of obtaining such information as states move forward with implementing some of them. She also discussed the importance of understanding what the motive or end goal is of regulating PBMs rather than making public policy on Court dicta in a decision.
Mr. Keen said the Subgroup would be supportive of developing a white paper, as has been discussed, if that is what the Task Force decides should be the next step after adoption of the PBM model.

Commissioner Conway said NAIC staff will schedule a meeting prior to its already scheduled March 25 meeting to consider adoption of the draft PBM model. He requested comments from Task Force members. Commissioner Schmidt suggested that the draft PBM model should include a reference to the Rutledge decision. Commissioner Conway acknowledged her suggestion, but he questioned whether the NAIC has included such references in other NAIC models. Mr. Beatty expressed support for Commissioner Schmidt’s suggestion. Commissioner Conway agreed that there needs to be further discussion of the Rutledge decision, but he suggested that the better setting for such a discussion would be in the proposed white paper.

Having no further business, the Regulatory Framework (B) Task Force adjourned.
The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met Jan. 28, 2021. The following Working Group members participated: Katie Dzurec, Chair, Shannen Logue and Frank Callihan (PA); Jane Beyer, Vice Chair. Jeanette Plitt, Paul Dubois and John Haworth (WA); Jimmy Harris, Donna Lambert, Crystal Phelps and Chantel Allbritton (AR); Mary Boatright, Jeanette Henagan, Erin Klug and Vanessa Darrah (AZ); Pam O’Connell, Jessica Ryan, Doris Walker, Sheirin Ghoddoucy and Christopher Citko (CA); Cara Cheevers, Kate Harris and Damion Hughes (CO); Kurt Swan, Courtney Miner, Paul Lombardo and Robert Chester (CT); Howard Liebers and Mary Beth Senkewicz (DC); Sarah Crittenden (GA); Cynthia Banks Radke, Sonya Sellmeyer, Angela Burke Boston, Lindsay Bates, Andria Seip and Jan Jones (IA); Ryan Gillespie, Sara Stanberry, Kate Morthland and Erica Weyhenmeyer (IL); Shannon Lloyd, Chris Hollenbeck, Craig VanAalst, Brenda Johnson, Barbara Torkelson, Tate Flott, Julie Holmes and Mark McClaffin (KS); Erica Bailey (MD); Peter Brickwedde and Andrew Kleinendorst (MN); Jeannie Keller (MT); Ted Hamby, Rosemary Gillespie, Shane Quinlan, Kathy Shortt, Tracy Biehn and Cheryl Bivens (NC); Sara Gerving, Colton storseth, Chystal Bartuska and Ross Hartley (ND); Ingrid Marsh, Michelle Heaton, and Tyler Brannen (NH); Ralph Boeckman, Gale Simon, Erin Porter and Chanell McDevitt (NJ); Sheri Mortensen-Brown, Viara Ianakieva, Diane Bilodeau, Julie Weinberg and Sarah Grisham (NM); Laura Miller, Guy Self, Kyla Dembowski, Todd Oberholtzer, Molly Motttram and Marjorie Ellis (OH); Alyssa Metivier, Victor Woods, Emily Maranjian and John Garrett (RI); Kendall Buchanan and Michael Bailes (SC); Jill Kruger and Lisa Harmon (SD); Rachel Bowden and Angela Melina Raab (TX); Tani J. Northrup, Carrie Backus, Heidi Clausen, and Jaakob Sundberg (UT); Brant Lyons, Melissa Gerachis, Heather Webb, Ansley Fitzpatrick, Bryan Wachter, Jarod Mentzer, Julie Fairbanks and Tiffany Toney (VA); Barbara Belling, Jody Ullman, Diane Dambach and Mark Prodoehl (WI); Joylynn Fix (WV); and Denise Burke, Tara Howard and Mavis Earnshaw (WY).

1. **Heard a Presentation on Consumer Experiences with MHP**

Andrew Sperling (National Alliance on Mental Illness—NAMI) provided an overview of federal mental health parity (MHP) legislation and its interaction with state laws. He characterized the law as a success for consumers, but he said challenges remain, including enforcement and a lack of clarity on non-quantitative treatment limits (NQTLs). He said state insurance regulators should ensure compliance when behavioral health benefits are carved-out, tackle the difficulties of network adequacy in mental health, and work toward a recognized accreditation process, such as through URAC. He said the prospective medical management of inpatient hospitalization remains a big challenge and a difference from the way medical/surgical (MS) benefits are treated.

Ms. Beyer asked whether there is concern with insurers approving a lower level of care than requested by a provider. Mr. Sperling said plans insist on a lower level of care, even calling the provider every day to ask for discharge from an inpatient setting. Ms. Beyer asked about experiences consumers have in appealing determinations that a lower level of care is all that will be paid. Mr. Sperling said it is a large challenge for families, especially when the patient is in crisis. Ms. Dzurec asked whether there are different definitions of emergency services for psychiatric care versus MS services. Mr. Sperling said there are different legal standards, particularly for involuntary confinement. He said these legal considerations complicate health plan determinations because these are legal proceedings where law enforcement may be involved. Ms. Harris asked whether there is an opportunity to use criteria from the American Society of Addiction Medicine (ASAM) to guide coverage decisions. Mr. Sperling said this is a hot topic and the challenge is that treatment guidelines are different for each condition.

2. **Heard a Presentation on Provider Experiences with MHP**

Tim Clement (American Psychiatric Association—APA) described health care providers’ experiences with MHP. He said utilization reviews for behavioral health often involve second-level review and peer-to-peer reviews in which the reviewer strongly encourages the provider to seek a lower level of care. He said smaller practices are at a disadvantage in negotiating with insurers, regardless of the scarcity of providers in a market. He outlined a number of prescription drug and formulary issues providers face. He urged state insurance regulators to look to medical experts in their states as well as state insurance regulators in other states who are performing parity market conduct exams.
3. **Heard a Presentation on Health Plan Experiences with MHP**

Lisa Campbell and Ryan Temme (Groom Law Group) presented on health plans’ perspectives on MHP. Ms. Campbell noted that their remarks represent the views of America’s Health Insurance Plans (AHIP), the Association for Behavioral Health and Wellness (ABHW), and the Blue Cross Blue Shield Association (BCBSA). Ms. Campbell described federal laws, noting the complexity of the tests for parity compliance. She referenced existing federal compliance tools. Mr. Temme emphasized the need for plans to better understand what would be considered compliant, particularly with regard to NQTLs. He described three levels of complexity with parity requirements: 1) a wide variety of covered plans; 2) the variety of approaches that are permissible; and 3) the different levels of analysis that a state insurance regulator could request. He said workforce shortages and the reluctance of providers to join networks contribute to the way plans offer and pay for mental health benefits and add to the complexity of compliance analysis. He said the rule is focused on the process, so different outcomes are not determinative of compliance. Ms. Campbell said federal guidance under recent legislation to require comparative analyses will provide a uniform standard for plans to report on their NQTLs.

Pamela Greenberg (ABHW) said her organization’s main goal is to have a uniform implementation process and certainty for plans regarding what is compliant and non-compliant. Randi Chapman (BCBSA) said her organization seeks clarity and wants the new federal law to lead to consistent and transparent guidance. She said the new law provides an opportunity for a uniform approach. Miranda Motter (AHIP) recommended that the Working Group work with stakeholders to implement the new federal law, and she said work outside the framework of the new law could add confusion.

Ms. Beyer asked what role issuers have in making it easier for behavioral health providers to be part of plan networks. Ms. Greenberg said some providers do not have the means to offer telehealth and plans have helped there. She said plans have worked to reduce the administrative burden and provider partnerships can be more complex than working in a solo practice without taking insurance. Ms. Motter said another potential consideration is providers operating at the top of their licenses. Ms. Greenberg said collaborative care models are a good example of psychiatrists practicing at the top of their licenses, and it can help for plans to encourage and reimburse such models.

Ms. Dzurec asked about using provider ratios in measuring network adequacy. Mr. Clement said whether providers are taking new patients is an important consideration in addition to provider ratio. Ms. Greenberg said the variety of provider types in behavioral health must also be considered. Ms. Motter said telehealth should also be considered with regard to satisfying provider ratios.

Ms. Dzurec asked about federal guidelines for comparative analyses and how states can ask plans for them. Amber Rivers (U.S. Department of Labor—DOL) said it is a transitional time and guidance will come later. She added that much of the language in the new law is borrowed from existing statutes and regulations, so the concepts are not new. Mary Nugent (Center for Consumer Information and Insurance Oversight—CCIIO) said guidance has not yet been released, but there is nothing in federal law that prevents state insurance regulators from requesting analyses from state-regulated plans.

Having no further business, the MHPAEA (B) Working Group adjourned.

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SENIOR ISSUES (B) TASK FORCE

Senior Issues (B) Task Force Feb. 23, 2021, Minutes ..........................................................7-31
Senior Issues (B) Task Force
Virtual Meeting (in lieu of meeting at the 2021 Spring National Meeting)
February 23, 2021

The Senior Issues (B) Task Force met Feb. 23, 2021. The following Task Force members participated: Marlene Caride, Chair (NJ); Lori K. Wing-Heier, Vice Chair, represented by Sarah Bailey (AK); Jim L. Ridling represented by William Rodgers (AL); Alan McClain represented by Carroll Astin (AR); Evan G. Daniels represented by Erin Klug (AZ); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Mary Beth Senkewicz (DC); Trinidad Navarro represented by Susan Jennette (DE); David Altmair represented by Chris Struk (FL); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Brenda Johnson (KS); James J. Donelon represented by Ron Henderson (LA); Gary D. Anderson represented by Rebecca Butler (MA); Kathleen A. Birrane represented by Adam Zimmerman (MD); Eric A. Cioppa represented by Sherry Ingalls (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartska (ND); Bruce R. Range represented by Laura Arp (NE); Chris Nicolopoulos represented by Maureen Belanger (NH); Barbara D. Richardson represented by Nick Stosic (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Ron Kreiter (OK); Andrew R. Stolfi represented by Gayle Woods (OR); Jessica K. Altman (PA); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Brian Hoffmeister (TN); Doug Slape represented by Doug Danzeiser (TX); Jonathan T. Pike represented by Tanji J. Norhurst (UT); Scott A. White represented by Bob Grissom (VA); Mike Kreidler represented by Michael Bryant (WA); and Mark Afable represented by Jennifer Stegall (WI). Also participating were: Eric Anderson (IL); Paige Duhamel (MN); Martin Wojcik (NY); Sarah Neil (RI); Andrew Dvorine (SC); Anna Van Fleet (VT); and Mavis Earnshaw (WY).

1. Discussed its 2021 Agenda

Commissioner Caride asked David Torian (NAIC) to summarize the potential agenda list. Mr. Torian explained the individual items the Task Force plans to do in 2021 and optional issue items the Task Force may wish to consider for the year.

Mr. Torian asked Ms. Arp to explain the issue Nebraska wishes to bring to the Task Force’s attention. Ms. Arp said Nebraska has durable medical equipment (DME) providers, or at least a provider, who has not taken assignment on certain DME products. She said the DME provider discovers that the person is on Medicare and has a Plan F, and the DME provider then charges “what he wants” or, at minimum, full retail for the equipment because he knows Plan F pays for 100% of the excess charges.

Ms. Arp said the federal government normally caps the excess amount on Part B at 15%, but that is not the case for DME. She said Plans F and G are then exposed to 100% of the cost of the DME product in this circumstance. She said in reaction, some carriers have said in their policy that the cost of the product must be medically necessary and the charge must be reasonable, while others may have utilized a usual, customary and reasonable (UCR) standard and limited the payment to that. She said the consumer who bought the Plan F then may be subject to “balance billing” based upon what the carrier did not pay to the DME provider.

Ms. Arp said the question becomes whether a Medicare Supplement carrier can limit the amount paid for the product even though there is no assignment and no cap imposed by the federal government like in other excess charges and what, if anything, would allow a carrier to not pay the full retail (or more) price imposed by a DME provider within the scope of the Medicare Supplement regulation model. She said Nebraska knows of some states that have imposed some restrictions on excess charges, but she also does not know, off hand, how many states have seen this issue arise.

Commissioner Caride asked if anyone has questions regarding the potential issues for the Task Force. Bonnie Burns (California Health Advocates—CHA) raised a concern about a class action lawsuit against Genworth. She said there are about 207,000 Genworth long-term care insurance (LTCI) policyholders who will receive a notice regarding the settlement of this class action lawsuit, and the settlement includes 39,000 Californians with partnership policies. She said several thousand more Californians with non-partnership policies from Genworth will receive a similar notice about their benefit options and premium increases.

Ms. Burns said the class action notices received in California offer policyholders various options to reduce their benefits and premiums, and she said some options include a cash payment, while others include paid up benefits with no further premiums required. She said some policyholders may be given only two options if their existing benefits are for less than two or three years of coverage, and policyholders with more than three years but less than lifetime coverage may have three options. She
said policyholders with lifetime benefits may have as many as five options. She said the notice also includes information about a pending premium increase and the possibility of future increases, some of more than 500% for policyholders with lifetime benefits and more than 300% for policyholders with fewer years of benefits.

Ms. Burns said while the disclosure notices resulting from this lawsuit have been largely dictated by the court, notices with similar options were distributed because of the Penn Treaty insolvency, and they are likely to be replicated if other insolvencies occur. In addition, she said the industry has begun to offer various options designed to reduce or eliminate a scheduled premium increase. She said consumer representatives are concerned that policyholders often do not understand the choices they are given or the implications of making one or more of these choices. She said she understands that the issue of reduced benefit options (RBO) is part of the workstream of the Long-Term Care Insurance (EX) Task Force, and she believes the issue deserves discussion within the Senior Issues (B) Task Force, a group that primarily deals with issues affecting older consumers and the model law and regulation for these products.

Ms. Klug asked Ms. Burns if the Task Force could move forward on this issue separate from the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup. Ms. Burns said yes because consumers must have options, and the Task Force is the group that can address issues in the model. Mr. Knable asked Ms. Burns about the letters going to policyholders and the format, as relates to the model. Ms. Burns said the Task Force should discuss the formatting of these letters and notices, as reflected in the model. Mr. Knable said since this is a class action lawsuit, this matter is probably outside of the NAIC models, as well as perhaps the NAIC jurisdiction and reach. Ms. Nakasone said a standardized letter would not be helpful, as one size does not fit all. Mr. Knable asked about the role of the Long-Term Care Insurance Model Update (B) Subgroup in this matter.

Mr. Torian explained that the purpose of the Long-Term Care Insurance Model Update (B) Subgroup is to first determine whether the Long-Term Care Insurance Model Act (#640) and the Long-Term Care Insurance Model Regulation (#641) need to be updated. If the Subgroup determines that an update is needed, the Subgroup will report to the Task Force on its findings and begin work to update Model #640 and Model #641. Mr. Torian said if the Subgroup determines that Model #640 and Model #641 do not need an update, then the Subgroup is prepared to act on any recommendations that may come from the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup. Mr. Torian said the Subgroup could begin its work immediately on whether Model #640 and Model #641 need an update, and it would most likely have not yet begun any edit or update on Model #640 and Model #641 prior to any potential recommendations that may come from the Subgroup.

Commissioner Caride asked the Task Force if there are any objections by Task Force members to let the Long-Term Care Insurance Model Update (B) Subgroup begin its work. Mr. Lombardo said he has no objection so long as the Subgroup can be prepared to receive any recommendations that may come from the Long-Term Care Insurance (EX) Task Force and any of its workstreams. Mr. Bryant said he has no objection, but he pointed out that the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup is looking at the issues raised by Ms. Burns. Commissioner Caride heard no objections, and she said the Long-Term Care Insurance Model Update (B) Subgroup should begin its work.

Commissioner Caride asked if there are any other issues the Task Force should consider for the year outside of the list provided to the Task Force. Ms. Burns said she would like the Task Force to look at innovative benefits in Medicare Supplement (Medigap). She said she has raised this before and feels these new or innovative benefits confuse consumers, cannot be compared with others, and dilute the simplification of standardized benefits. Commissioner Caride asked Ms. Burns to send details to Mr. Torian. Ms. Nakasone said Ms. Burns if she could include examples of the type of benefits and rewards.

Harry Ting (Consumer Advocate Volunteer, Chester County Department of Aging Services – Apprise Program) said he has an issue that has disturbed State Health Insurance Assistance Program (SHIP) counselors for years; i.e., Medicare Part D insurers that drop a low premium plan and auto-enroll Medicare beneficiaries in their highest cost plan during annual open enrollment. Beneficiaries are sent the federal Center for Medicare & Medicaid’s (CMS’s) standard Annual Notice of Changes letter and standard CMS changes booklet, which combined are around 16 pages long. Unless beneficiaries read the documents carefully, they may not even understand that their plan has changed. Even if they do, they are only given information on how their new plan's provisions and premiums differ from that of their old plan. They are not informed that there is a cheaper option offered by the company, whose premium is closer to the old premium.

Commissioner Caride asked Mr. Ting to also send details to Mr. Torian. Ms. Burns said the NAIC should take a position on the return of state regulation of Medicare Advantage, and she encouraged the states to learn more about and use the Senior Medicare Patrol (SMP) program, which is often housed in the SHIP, and one-third of SHIPs are in a state insurance department. She said these programs are the primary source in each state for frauds perpetrated against seniors.

Having no further business, the Senior Issues (B) Task Force adjourned.
PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

Property and Casualty Insurance (C) Committee April 13, 2021, Minutes ................................................................. 8-2
Cannabis Insurance (C) Working Group March 11, 2021, Minutes (Attachment One) .................................................. 8-7
Catastrophe Insurance (C) Working Group March 10, 2021, Minutes (Attachment Two) ........................................... 8-10
Catastrophe Insurance (C) Working Group Nov. 17, 2020, Minutes (Attachment Two-A) ....................................... 8-16
Pet Insurance (C) Working Group April 8, 2021, Minutes (Attachment Three) .......................................................... 8-20
Pet Insurance (C) Working Group March 26, 2021, Minutes (Attachment Three-A) ................................................... 8-21
Pet Insurance (C) Working Group Feb. 18, 2021, Minutes (Attachment Three-A1a) .................................................... 8-26
Transparency and Readability of Consumer Information (C) Working Group March 15, 2021, Minutes
(Attachment Four) ........................................................................................................................................... 8-28
Transparency and Readability of Consumer Information (C) Working Group Feb. 4, 2021, Minutes
(Attachment Four-A) .......................................................................................................................................... 8-31
Transparency and Readability of Consumer Information (C) Working Group Nov. 17, 2020, Minutes
(Attachment Four-B) ........................................................................................................................................... 8-32
The Property and Casualty Insurance (C) Committee met April 13, 2021. The following Committee members participated: Vicki Schmidt, Chair (KS); Mike Chaney, Vice Chair (MS); Jim L. Ridling (AL); Ricardo Lara represented by Ken Allen (CA); Andrew N.Mais and George Bradner (CT); Colin M. Hayashida and Martha Im (HI); Stephen W. Robertson represented by Kate Kixmiller (IN); James J. Donelon (LA); Kathleen A. Birrane (MD); Grace Arnold (MN); Larry D. Deiter represented by Maggie Dell (SD); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler represented by Eric Slavich (WA); and James A. Dodrill (WV). Also participating were: Lori K. Wing-Heier (AK); Phil Vigliaturo (MN); Martha Lees and My Chi To (NY); Michelle Brugh Rafeld (OH); and Don Beatty (VA).

1. **Adopted its 2020 Fall National Meeting and 2020 Summer National Meeting Minutes**

Commissioner Birrane made a motion, seconded by Commissioner Chaney, to adopt the Committee’s Dec. 8, 2020 (see NAIC Proceedings – Fall 2020, Property and Casualty Insurance (C) Committee) and Aug. 12, 2020 (see NAIC Proceedings – Summer 2020, Property and Casualty Insurance (C) Committee) minutes. The motion passed unanimously.

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

Mr. Vigliaturo reported that the Casualty Actuarial and Statistical (C) Task Force regularly holds predictive model training called the “Book Club” and a monthly regulator-only discussion about rate filing issues. He said non-actuaries are encouraged to attend. He said the Task Force is concerned about potential consequences of the Casualty Actuarial Society’s (CAS) recission of its Statement of Principles for Ratemaking (SOP). He said the Task Force adopted a letter to the CAS Board requesting that the CAS consider reversing its decision. In March, the CAS Board voted to not reverse its position, but to ask the American Academy of Actuaries (Academy) to develop a practice note to attempt to provide some concise and useful communication about ratemaking that is not included in Standards of Practice. Mr. Vigliaturo said the Consumer Federation of America (CFA) sent a letter to all commissioners, superintendents and directors requesting that they make revisions to their laws and/or regulations and has specifically pointed out that while the considerations in the rescinded SOP are included in Standards of Practice, the principles themselves, which are the most important part, are not included in standards. Mr. Vigliaturo said the Task Force will be addressing this issue during its future meetings.

Mr. Vigliaturo also provided an update on NAIC rate review activities, specifically the confidential shared model database and the NAIC rate model technical review process that were created for use by states that signed the Rate Review Support Services Agreement. Currently, 28 states have signed the agreement, and the NAIC has reviewed 31 rate filings and subsequent objection responses coming from nine different states. Mr. Vigliaturo reported that over the last year, the NAIC has added an expert modeling actuary and is in the process of considering two additional resources to assist with the increasing volume of requests.

Bob Hunter (CFA), with respect to the CAS SOP for Ratemaking, said no other actuarial standards or principles apply to final rates, and the rates that matter are final rates because that is what consumers pay and state insurance regulators regulate. He also noted that the state rate-making laws have aligned with the actuarial principles because the principles interpreted the statutory language of what is not excessive, inadequate or unfairly discriminatory meant. Some state statutes and regulations actually refer to sound actuarial principles. He said companies have been moving to pricing based upon willingness to pay and departures from cost-based pricing like price optimization. Mr. Hunter urged the Committee to indicate an intent to continue to rely upon the principles in regulatory processes. He said since a lot of model laws and state laws mention sound actuarial principles, any references should be replaced with the language of the rescinded principles. Commissioner Schmidt noted that the Task Force will continue to discuss these developments during future meetings.

Jessica Leong (CAS) said that as president of the CAS, the professionalism of members is extremely important, and that the CAS did receive feedback on its rescinding of the SOP. She said moving forward with the Academy to redraft a new document can fulfill some of the needs in terms of having a document that will be useful to non-actuaries in messaging about ratemaking.

Commissioner Donelon said the Surplus Lines (C) Task Force has not yet met in 2021, but during its next meeting, it will be discussing a strategy to update the Nonadmitted Insurance Model Act (#870). The Task Force will also be reviewing and discussing amendments to the Standard Form Trust Agreement for Alien Excess or Surplus Lines insurers, as well as amendments to the International Insurers Department (IID) Plan of Operation, which govern the more than 165 alien insurers and syndicates doing business in the U.S.
Ms. Rafeld said the Title Insurance (C) Task Force met Feb. 23 and took the following action: 1) heard the first half of a presentation from the American Land Title Association (ALTA) on the effects that the COVID-19 pandemic had on the title insurance industry; and 2) discussed a proposed work plan for the year, which includes: considering drafting a memorandum to the Government Relations (EX) Leadership Council to study the issues related to the Secure and Fair Enforcement (SAFE) Banking Act and U.S. Department of Justice (DOJ) “Cole” memorandum to determine if the NAIC should take certain positions or additional steps related to these; considering drafting a memorandum to the Producer Licensing (D) Task Force in combating fraud through joint calls and meetings; 3) monitoring issues and developments occurring in the title insurance space.

Director Wing-Heier said the Workers’ Compensation (C) Task Force met March 15 and heard presentations from the International Association of Industrial Accident Boards and Commissions (IAIABC) and the National Council on Compensation Insurance (NCCI) regarding COVID-19. The IAIABC has been collecting data regarding COVID-19 workers’ compensation claims, including the number of claims received; the number of fatalities; the denial rates; and rates per 100,000 workers in those claims. The NCCI presented information regarding COVID-19 claims, presumptions, combined ratios, COVID-19 loss summaries and other legislative issues being introduced this year. The NCCI reported that the calendar year combined ratios are expected to be favorable. There has not been an explicit adjustment made for COVID-19 in the recent rate and loss cost filings, and the NCCI still does not know what the final impact of COVID-19 will be. However, it is working with several modeling firms to evaluate the exposure.

Mr. Allen said the Cannabis Insurance (C) Working Group met March 11 and took the following action: 1) reviewed its current charges and how they should be addressed; and 2) discussed a proposed work plan for the year, which includes: considering drafting a memorandum to the Government Relations (EX) Leadership Council to study the issues related to the Secure and Fair Enforcement (SAFE) Banking Act and U.S. Department of Justice (DOJ) “Cole” memorandum to determine if the NAIC should take certain positions or additional steps related to these; considering drafting a memorandum to the Producer Licensing (D) Task Force in combating fraud through joint calls and meetings; 3) monitoring issues and developments occurring in the title insurance space.

Commissioner Chaney said the Catastrophe Insurance (C) Working Group met March 10 and took the following action: 1) heard federal updates from NAIC staff regarding the National Flood Insurance Program (NFIP) and the U.S. Department of Housing and Urban Development (HUD) proposed rule to change the Federal Housing Administration (FHA) regulations to allow lenders to accept private flood insurance policies located in special flood hazard areas; 2) heard a presentation from Q-risq Analytics regarding a product that runs storm surge and wind velocity models prior to a storm making landfall. The product provides data down to an individual address that is geocoded with a latitude and longitude. Commissioner Chaney noted Mississippi was able to take advantage of using this product during the hurricane season; and 3) heard presentations from Alabama, California, Louisiana, Mississippi and Texas regarding catastrophic events occurring over the past year.

Mr. Beatty said the Pet Insurance (C) Working Group is in its final stages of adopting a Pet Insurance Model Act. All sections of the model have been exposed for comment. The main issues covered are definitions, disclosure, preexisting condition clauses and waiting periods. Mr. Beatty said there has been participation from numerous interested parties, and he is hopeful the model might be complete by the Summer National Meeting.

Ms. Lees said the Terrorism Insurance Implementation (C) Working Group has not met this year, but there are some updates on activities related to the state regulator data call. She said workers’ compensation data has been received and is being analyzed by the NAIC in order to create a report as in prior years. Ms. Lees said the joint data templates for the state insurance regulator data call were released and a notification sent to insurers on March 12 asking insurers to file 2020 data for the 2021 joint data call by May 15 to both state insurance regulators through the New York portal and to the U.S. Department of the Treasury (Treasury Department). She said a regulator-to-regulator meeting has been scheduled to discuss the state supplement portion of the 2021 data call, and details will be sent to insurers once a decision is made by state insurance regulators. This notification should occur in May.
Mr. Bradner said the Transparency and Readability of Consumer Information (C) Working Group is currently working on a “best practices” document for state insurance regulators regarding significant premium increases on property/casualty (P/C) insurance products. There are three drafting groups working on various sections of the document. These drafting groups include: discussing and drafting a section of the best practices document regarding a threshold for notification of a premium increase, communication of a premium increase and communication standards for a premium increase; drafting a generic rate and rule filing checklist that can be used by a department of insurance (DOI); and drafting consumer education regarding premium increases. Mr. Bradner said the drafting groups have begun meeting and plan to meet monthly.

Commissioner Chaney made a motion, seconded by Commissioner Kreidler, to adopt the following task force and working group reports: Casualty Actuarial and Statistical (C) Task Force; Surplus Lines (C) Task Force; Title Insurance (C) Task Force; Workers’ Compensation (C) Task Force; Cannabis Insurance (C) Working Group (Attachment One); Catastrophe Insurance (C) Working Group (Attachment Two); Pet Insurance (C) Working Group (Attachment Three); Terrorism Insurance Implementation (C) Working Group; and Transparency and Readability of Consumer Information (C) Working Group (Attachment Four). The motion passed unanimously.

3. **Adopted an Extension for Revisions to the Proposed Pet Insurance Model Act**

Commissioner Dodrill made a motion, seconded by Mr. Bradner, to adopt an extension to the 2021 Summer National Meeting for revisions to the proposed Pet Insurance Model Act. The motion passed unanimously.

4. **Heard an Update Related to Workshops Concerning Disaster Preparedness and Response**

Aaron Brandenburg (NAIC) said state insurance regulators held a workshop with Federal Emergency Management Agency (FEMA) Regions 8, 9 and 10 in February. The workshop had set out to build upon existing relationships and identify new partnership opportunities for all phases of disaster management. It covered both NAIC and federal publications and resources on resiliency disaster preparedness and response; DOI disaster response organizational charts; communications; and sharing of key contacts. He said additional communication from FEMA on Risk Rating 2.0 to state insurance regulators is expected to occur before or during the upcoming Insurance Summit. The regions will also consider possible formation of an ongoing working group for continued engagement regarding individual assistance, disaster recovery center collaboration, data sharing and post-event reports covering lessons learned.

Mr. Brandenburg also reported that the pre-disaster mitigation workstream under the Climate and Resiliency (EX) Task Force worked with the NAIC Center for Insurance Policy and Research (CIPR) as well as the Federal Alliance for Safe Homes (FLASH) to co-host a building code and mitigation workshop in May. The workshop was reported on during the Climate and Resiliency (EX) Task Force meeting, and recordings with slides and resources from the event are posted on the Climate and Resiliency Resource Center. The workshop covered information on building codes; proven mitigation methods, including state programs; and funding resources for pre- and post-event mitigation. He said additional sessions will occur at the upcoming Insurance Summit in June.

Mr. Brandenburg also noted the Catastrophe Insurance (C) Working Group tasked NAIC staff with creating a disaster hub where regulatory information related to disasters could be housed. He said a prototype website has been created that has recordings and materials from prior FEMA workshops; regulatory resources like the State Disaster Response Plan and information on the NAIC’s disaster assistance capabilities such as data calls; state bulletins that can be used by states as they prepare for disasters; consumer documents; and FEMA resources. He also said a list of each state’s disaster contact is also posted.

5. **Appointed an NAIC/FEMA Advisory Group**

Commissioner Chaney said the workshops and additional engagement with FEMA have been extremely valuable to state insurance regulators by building relationships, discussing communication strategies, and committing to working together before, during and after disasters. He said some of the Southeast Zone states in FEMA Region 4 have agreed to create a working group to meet on a regular basis. One of the keys that has been discussed throughout these workshops is to ensure that conversations and engagement move forward. Commissioner Chaney said he would propose a new group be formed under the Catastrophe Insurance (C) Working Group to serve as an advisory group to provide oversight, planning, prioritization and a reporting mechanism for state insurance regulator and FEMA interaction. The group would help to make sure that state insurance regulators continue to work closely with FEMA to improve disaster preparation and resilience. Upon a motion by Commissioner Chaney, seconded by Commissioner Ridling, the following charge was adopted:
The NAIC/FEMA Advisory Group will assist state regulators in engaging and collaborating with FEMA on an ongoing basis by establishing a process for the oversight, prioritization and reporting of disaster-related regional workshops and other exercises to improve disaster preparation and resilience.

6. **Heard a Presentation Related to Insurance Rating for Dog Breeds**

Grace Lopes (Insurance Consumer Coalition for Pet Owners) said nine animal welfare groups issued a white paper in November 2020 about dog breed rating. She said homeowners sometimes go uninsured or underinsured because insurance companies are refusing to write a policy, excluding animal liability, or placing monetary limits on coverage due to dog breed lists that contain 13 breeds. She said this dog list was created by the Centers for Disease Control and Prevention (CDC) and later rejected by the CDC 25 years ago. She said the insurance industry has added a mix of any of the 13 breeds, which encompasses most dogs in dog shelters. She said experts agree that breed does not dictate behavior.

Ms. Lopes said the Insurance Information Institute (III) produces a report about how much dog claims cost that is based on all dog-related claims, including slip and fall accidents and other liability issues beyond dog bites. She said visual breed identification is unreliable, and DNA testing is the only reliable method to determine genetic heritage. She said no tests or breed label can predict dog behavior. Ms. Lopes said insurers make exceptions to the dog breed list with a higher premium. She said some insurers and associations have rejected the dog breed list. She said uneducated insurance consumers, low- or moderate-income consumers, and people of color are most harmed by the use of dog lists. She said more people have rescued dogs during the pandemic.

Ms. Lopes said underwriting guidance should not be arbitrary or capricious. She asked the Committee to determine whether actuarial data exists to support a breed list. She asked for countrywide data call to be issued to collect data on dog bites and that states issue a moratorium on the use of the breed list until the data is reviewed.

7. **Discussed the Status of Potential Charges Related to Race and Insurance Issues**

Commissioner Schmidt said the Special (EX) Committee on Race and Insurance met April 12 and discussed some proposed charges that are currently exposed for comment through May 14. Workstream Three of the Special Committee had previously met several times and drafted recommendations for the Special Committee. The Special Committee incorporated those recommendations into proposed charges having to do with affordability, availability and access; producer issues; consumer education and outreach; and unfair discrimination, including defining terms like “proxy discrimination” and “disparate impact” and developing regulatory and analytical tools as they relate to these issues and others, like the use of third-party data and certain socioeconomic rating variables. Commissioner Schmidt said the Committee will end up working on many of these issues either directly or indirectly. Birny Birnbaum (Center for Economic Justice—CEJ) said he looks forward to working with commissioners on defining terms and developing a framework to address racism in insurance.

8. **Discussed Cyberinsurance Charge and Heard a Report on the New York Cyber Insurance Framework**

Commissioner Schmidt said the Committee has a charge related to analyzing the cybersecurity insurance market. She said NAIC staff will present a report on the Cybersecurity Insurance and Identity Theft Coverage Supplement during a future meeting.

Ms. To said the New York State Department of Financial Services (NYDFS) recently hired Justin Herring as Executive Deputy Superintendent of the Cybersecurity Division. She said Mr. Herring was previously chief of the U.S. Attorney’s office in New Jersey’s first cybercrimes unit. Ms. To said as cyber risks are increasing, New York decided to focus on cyber insurers because they are uniquely exposed to cyber-risk from a solvency perspective and because they are uniquely positioned to help raise the bar in terms of cybersecurity best practices in the corporate world more generally. She said the New York Cyber Insurance Risk Framework is a good example of collaboration and what can come out of constructive dialogue between state insurance regulators and the industry.

Mr. Herring reported the cyberinsurance market is likely to grow from around $3 billion in premiums in 2019 to a projected $20 billion in 2025. He said growth slowed in 2019, but premiums understate exposure. The slow growth was driven by the increasing cost of cyberattacks and exposure of ransomware. Ransomware imposes many new costs and introduces the possibility a business or city could actually be shut down. Mr. Herring said that cost has made insurers more cautious in underwriting and has slowed the growth of the market.

Mr. Herring said the three key challenges of cyber-risk measurement are: 1) silent risk, meaning many cybercrimes could generate claims that are not under policies that specifically refer to cybercrimes, such as business interruption or liability
policies; 2) systemic or aggregation risk, meaning cyber incidents sometimes affect many organizations at the same time; or 3) rapid change, meaning cybercrime methods change very quickly.

Mr. Herring said the NYDFS issued a ransomware survey in 2020 of insurers to find out how ransomware costs had changed, finding they almost doubled. He said the NYDFS then met with other regulators like the European Insurance and Occupational Pensions Authority (EIOPA) and the Bank of England and with cyberinsurers. He said the NYDFS had cyberinsurance roundtables with large cyberinsurers, insurance brokers and cybersecurity experts. Mr. Herring said the NYDFS developed seven recommendations in the Cyber Insurance Risk Framework. Some insurers had already incorporated the recommendations. The recommendations are: 1) establish a formal cyberinsurance risk strategy; 2) manage and eliminate exposure to silent cyberinsurance risk; 3) evaluate systemic risk; 4) rigorously measure insured risk; 5) educate insured and insurance producers; 6) obtain cybersecurity expertise; and 7) require notice to law enforcement.

Having no further business, the Property and Casualty Insurance (C) Committee adjourned.
The Cannabis Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met March 11, 2021. The following Working Group members participated: Ricardo Lara, Chair, represented by Melerie Michael-Brown-Brown and Camilo Pizarro (CA); Michael-Brown Conway, Vice Chair, represented by Peg Brown and Bobbie Bacca (CO); Lori K. Wing-Heier represented by Austin Childs (AK); Angel King (DC); Michael-Brown Gould (DE); Judy Mottar (IL); Marlene Caride represented by Nicole A. Brown and Randall Currier (NJ); Gennady Stolyarov and Mark Garratt (NV); Glen Mulready (OK); Andrew R. Stolfi represented by Raven Collins (OR); Elizabeth Kelleher Dwyer (RI); Christina Rouleau (VT); and Michael-Brown Bryant (WA).

1. Discussed its 2021 Work Plan

Ms. Michael-Brown stated that the Working Group did not meet in 2020 due to COVID-19. For this reason, it is important for the Working Group to review where it left off in 2019 before discussing what it should do in 2021. The Working Group was appointed by the Executive (EX) Committee during its Aug. 5, 2018, meeting to study insurance issues related to legal cannabis business. The Working Group’s major deliverable was drafting the white paper Understanding the Market for Cannabis Insurance, which it adopted in July 2019. The white paper was then fully adopted by the Executive (EX) Committee and Plenary during the 2019 Fall National Meeting. The white paper explored regulatory issues related to insurance in the cannabis industry, including how insurance rates are set; legal and regulatory authority at the federal, state and local levels; cannabis operations; and best practices. The white paper findings showed there are substantial gaps in insurance coverage for the cannabis industry, exposing those who engage with the cannabis industry.

Given the completion of its charge to develop the white paper, the Working Group proposed that its charges be updated for 2020. Since the Working Group did not meet in 2020, these charges have carried through to 2021. The charges include:

1) Assess and periodically report on the status of federal legislation that would protect financial institutions from liability associated with providing services to cannabis businesses operating legally under state law.

2) Encourage admitted insurers to ensure coverage adequacy in states where cannabis, including hemp, is legal.

3) Provide insurance resources to stakeholders and keep up with new products and innovative ideas that may shape insurance in this space.

4) Collect aggregated insurance availability and coverage gap information, as well as other cannabis and hemp insurance-related data to then publicly share the cannabis and hemp insurance-related data in a released report by the end of 2021.

The Working Group determined at the end of 2019 that its 2020 charges should include the evaluation of commercial insurance issues, including issues related to commercial auto, workers’ compensation and hemp. In determining this, it noted that both hemp and marijuana come from the same cannabis species. Additionally, many states are tracking hemp issues in parallel with marijuana issues, as businesses operating in both of these spaces face many of the same issues, such as banking and insurance availability. However, the Working Group believed issues related to impairment and safety extend beyond just cannabis-related issues and should be undertaken as part of a comprehensive effort under other working groups. The Working Group also determined that capturing information on coverage adequacy, such as the number of insurers writing in a state and what coverages they offer, was not feasible. The decision was based on the Working Group’s unsuccessful attempts to do this previously when it asked the states to verify similar information collected from the National Cannabis Industry Association (NCIA).

The proposed work plan for 2020 includes:
1. Consider drafting a memorandum to the Government Relations (EX) Leadership Council to consider NAIC support of the Secure and Fair Enforcement (SAFE) Banking Act.

2. Consider drafting a memorandum to the Government Relations (EX) Leadership Council asking that it study the status of issues related to the U.S. Department of Justice (DOJ) Cole Memorandum.

3. Hold a fact-finding hearing to hear from insurance companies on barriers they experience in expanding coverage availability in this space.

4. Consider drafting a memorandum to the Producer Licensing (D) Task Force asking that it examine how cannabis-related convictions may be preventing licensing approvals.

The first two work plan items are aimed at examining the current state of protections for financial institutions from liability associated with providing services to marijuana businesses operating legally under state law. The SAFE Banking Act was proposed legislation in 2019 regarding the disposition of funds gained through the cannabis industry. The Cole Memorandum stated that given its limited resources, the DOJ would not enforce federal marijuana prohibition in states that had legalized it. It was rescinded in 2018; in response, the Sensible Enforcement of Cannabis Act was introduced as a means to preserve the protections offered by the Cole Memorandum. As all NAIC policy positions go through the Government Relations (EX) Leadership Council, the Working Group’s memorandum would ask that the Leadership Council take up examining the SAFE Banking Act and the status of the Cole Memorandum to determine if the NAIC should take further steps or positions.

The third work plan item is related to the increasing need and demand for cannabis insurance as more states continue to legalize cannabis. A hearing would allow the Working Group to get feedback from insurers on what state insurance regulators can do to help remove the barriers they are experiencing in offering coverage. Colorado shared in 2019 that after conducting a survey, it found that coverage for hemp is much different than it is for cannabis. As such, the hearing may also need to include a discussion on how the U.S. Department of Agriculture (USDA) and the Federal Crop Insurance Corporation affect the hemp industry. The findings from the hearing can be summarized in some sort of deliverable, such as a brief report to fulfill the Working Group’s fourth charge. The fourth work plan item aims at how licensing efforts can increase diversity.

Mr. Stolyarov requested that the fourth work plan item be edited to hyphenate “cannabis-related.” Ms. Michael-Brown agreed.

Ms. Brown suggested that the third work plan item be modified to allow for the possibility of a lengthier deliverable, potentially a report extending beyond one page, if the content that needs to be covered warrants it. Ms. Michael-Brown agreed.

Ms. Brown asked for clarification on whether the second charge should be to “improve coverage adequacy” or “ensure coverage adequacy.” Ms. Michael-Brown stated that the official second charge is to “ensure coverage adequacy.”

Lisa Brown (American Property and Casualty Insurance Association—APCIA) stated that insurers would benefit most by NAIC support of the SAFE Banking Act. Although the Cole Memorandum stated that the DOJ would not enforce federal marijuana prohibition in states where it is legal, carriers would be more comfortable with something definitive. The industry would like to request that states consider their legal inability to provide cannabis insurance coverage under federal law before any individual state makes coverage mandatory.

Superintendent Dwyer stated that she regulates securities and banking in addition to insurance in Rhode Island. The Conference of State Bank Supervisors (CSBS) discussed the SAFE Banking Act and the Cole Memorandum on its March 10 call. Surprisingly, Rhode Island has found that its state charters banking marijuana have been unchanged. She suggested that the NAIC government relations staff reach out to the CSBS to find out more, as it seems there is less angst around this issue now. As chair of the Producer Licensing (D) Task Force, she supports the fourth work plan item, but she suggests that it be expanded to include the entire 1033 guidance, which includes all criminal backgrounds for producer licensing. She asked if there is any evidence that producer licenses are being held up by marijuana convictions.

Ms. Michael-Brown stated that she did not know, but research into this can be included in the memorandum. California took the initiative to review and change its licensing protocols after legalizing cannabis, but she was unsure if other states did the same. The work plan item was designed to research this; see if there are any such barriers limiting diversity; and if so, create guidance for states on how to move forward.

Superintendent Dwyer stated that the guidelines on 1033, the federal statute relating to felonies, and who can participate in the insurance industry are extremely outdated. She noted that only those who have a federal marijuana trafficking conviction would
Ms. Michael-Brown stated that Attorney General Nominee Merrick Garland indicated in his confirmation hearing that if confirmed, he would shift back towards the Obama-era approach of limiting resources spent on federal marijuana enforcement.

Ms. Brown stated that insurers are not comfortable writing cannabis coverage with the risk that another administration or attorney general could withdraw support for considerations that the previous administration held under the Cole Memorandum. If insurers need to provide coverage for cannabis activities, the NAIC should support the SAFE Banking Act. As such, the industry would most benefit from the Working Group prioritizing this.

Ms. Brown stated that Colorado is doing a series of forums starting in April to encourage admitted carriers to enter the space. Most of the coverage in Colorado is provided by the nonadmitted market. Ms. Brown believes the Working Group needs to examine if anything should be added to the SAFE Banking Act to encourage admitted carriers to participate in this space. The Working Group should look closely to determine what mechanisms coverage is currently being provided. A surplus broker brought to Ms. Brown’s attention that the inability of admitted carriers to get reinsurance may be causing insurers’ reticence in entering this space. The surplus broker stated that this is important information in drafting the memorandum on the SAFE Banking Act, and she asked if Ms. Brown has any additional insight.

Ms. Brown stated that she would inquire internally and report back on her findings.

Keri Kish (Wholesale & Specialty Insurance Association—WSIA) stated that this parallels her understanding of how reinsurance is limiting admitted carriers from entering the space. She offered to find out more details and report back on her findings.

Having no further business, the Cannabis Insurance (C) Working Group adjourned.
The Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met March 10, 2020. The following Working Group members participated: Mike Chaney, Chair, and Andy Case (MS); Brian Powell (AL); Ken Allen, Giovanni Muzzarelli and Lynne Wehmueller (CA); George Bradner and Wanchin Chou (CT); Virginia Christy (FL); Colin M. Hayashida (HI); Travis Grassel (IA); Judy Mottar (IL); Heather Droge and Brenda Johnson (KS); Warren Byrd, Richard Piazza and Thomas Travis (LA); Matthew Mancini (MA); Joy Hatchette (MD); Cynthia Amann, Carrie Couch, LeAnn Cox and Jeana Thomas (MO); Timothy Johnson (NC); Mark McGill (NJ); Tom Botsko (OH); Cuc Nguyen (OK); David Dahl, Ying Liu and Van Pounds (OR); Elizabeth Kelleher Dwyer and Beth Vollucci (RI); Gwen McGriff and Will Davis (SC); David Combs (TN); Brian Ryder and Mark Worman (TX); and David Forte (WA). Also participating were: Vincent Gosz (AZ); Renee Campbell (MI); Chris Aufenthie (ND); Gennady Stolyarov (NV); and Donna Stewart (WY).

1. **Adopted its Nov. 17, 2020, Minutes**

The Working Group met Nov. 17, 2020, in lieu of meeting at the 2020 Fall National Meeting.

Mr. Byrd made a motion, seconded by Mr. Bradner, to adopt the Working Group’s Nov. 17, 2020, minutes (Attachment Two-A). The motion passed.

2. **Heard an Update Regarding Federal Legislation**

Brooke Stringer (NAIC) said the National Flood Insurance Program (NFIP) is operating under its sixteenth short-term extension, which will expire Sept. 30, 2021. She said lawmakers are divided over issues, such as the role of the private flood insurance market, claims processing reforms and addressing affordability challenges. Congressional debates will likely factor in the new Risk Rating 2.0 initiative, as this initiative will revamp the way premiums are calculated.

Ms. Stringer said recent media reports indicate that the Federal Emergency Management Agency (FEMA) has told insurers that it will stagger the rollout of the new NFIP rates under Risk Rating 2.0. New rates will only take effect for new flood insurance policies beginning Oct. 1, 2021, while rates for existing policies will not take effect until April 1, 2022. Ms. Stringer said this has not yet been publicly confirmed.

Ms. Stringer said that during the last Congress, the U.S. House of Representatives’ Committee on Financial Services approved a five-year reauthorization bill, but coastal state lawmakers objected to the bill and introduced an alternative bill. She said these lawmakers did not believe Chairwoman Maxine Waters’ (D-CA) bill went far enough to protect policyholders from rate hikes. Neither bill proceeded further in the House, nor was there any focus on the NFIP reauthorization in the U.S. Senate. Ms. Stringer said Chairwoman Waters and U.S. Rep. Emanuel Cleaver (D-MO)—who is chair of the Subcommittee on Housing, Community Development, and Insurance—indicated that a long-term reauthorization of the NFIP is one of the priorities for the new Congress. It is unlikely that the Senate Committee on Banking, Housing, and Urban Affairs will prioritize reauthorization until it gets closer to the expiration of the current short-term reauthorization. The NAIC will continue to urge support for a long-term reauthorization that prioritizes mitigation and encourages private market growth.

Ms. Stringer said FEMA has continued to purchase reinsurance to cover losses for the NFIP and transfer more risk to the capital market. She said the February transfer, combined with some of the previous capital market placements and the January reinsurance placement, FEMA has now transferred a more than $2.9 billion of the NFIP flood risk to the private sector ahead of the 2021 hurricane season.

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Ms. Stringer said that in November 2020, the U.S. Department of Housing and Urban Development (HUD) published a proposed rule to change Federal Housing Administration (FHA) regulations to allow lenders to accept private flood insurance policies on FHA-insured properties located in special flood hazard areas (SFHAs). The FHA’s current rules have prevented buyers with FHA-insured mortgages from obtaining flood insurance through any source other than the NFIP. In 2019, the federal banking regulators finalized their rule for acceptance of private flood insurance.
Ms. Stringer said the proposed rule would amend FHA regulations to include the definition of “private flood insurance” from the federal Biggert-Waters Flood Insurance Reform Act of 2012. It includes a “compliance aid” allowing mortgagees to accept private policies, without further review, where the policy or an endorsement includes the language that it meets this definition of private flood insurance laid out in the rule. The proposal differs from the federal banking regulators’ private flood rule, particularly because it would not allow discretionary acceptance of other types of private flood insurance policies, including residential surplus lines policies.

Ms. Stringer said the NAIC submitted a comment letter in January 2021 encouraging HUD to further align its rule with the banking regulators and providing information on the regulatory regime for surplus lines insurance. She said, with the change in administration, it is unclear yet if HUD will continue to pursue such a new rule. Ms. Stringer will keep the Working Group apprised of updates.

3. Heard a Presentation from Q-risq Analytics

Q-risq Analytics (Q-risq) showed a short video. This video described an operational solution it has developed for forecasting address-specific wind and storm surge risk using geospatial analytics engines developed for federal, state and local emergency managers.

According to Q-risq, its product helps answer the following questions: 1) Who will be affected by the approaching storm surge and tropical winds? 2) What will be the intensity of the surge and wind when the storm makes landfall? 3) When is the impact of the approaching storm expected to begin? 4) Where should the most experienced personnel be deployed prior to landfall for the quickest response time? and 5) How will the storm affect individual property owners and the community as a whole?

The Q-risq team consistently monitors a storm’s track, the wind intensity and surge risk area days prior to a storm. This information can be used to contact property owners, municipalities and government entities via text message, email and/or voice calls to help them prepare for a storm’s effects and to help mitigate damage.

When received in advance, each address is geocoded with a precise latitude and longitude and entered into Q-risq’s secure client database and digitally represented in its program’s viewer. Each policy address is assigned an individual risk score based on its forecasted flood depth and its digitally derived ground elevation. Properties are then classified in one of four categories: 1) no risk; 2) low risk; 3) moderate risk; or 4) high risk.

Properties can be close to each other but assigned different risk levels. Q-risq’s proprietary wind and storm surge model results are layered over ground elevations. Customized assessments are built for each property. Properties that sit higher will not be as affected by a given amount of water. As seen with 2020’s Hurricane Laura Q-risq’s proprietary wind model Q-winds color codes the storm’s four-quadrant wind vortex according to maximum velocity. Updated with each National Hurricane Center (NHC) advisory, each property is then classified according to its forecasted wind risk.

In addition to client-specific policies in force, Q-risq also ingests community addresses to provide impact assessments to federal, state and local governments, aiding and preparing proportionate levels of staging and response teams. Well before landfall, Q-risq’s supercomputer uses real-time storm information to perform billions of calculations on hundreds of terabytes of data to calculate an ensemble of storm impact possibilities. This information is processed against the previously geocoded properties to determine community exposure for both surge and wind. Once the storm has made landfall, Q-risq focuses on creating a hindcast report of the storm’s impact. Maximum storm surge, sustained winds and accumulated rainfall are displayed in a spreadsheet for each location. The Q-risq team is committed to improving the ability to reach out to homeowners, public assistance applicants and emergency management personnel with the most advanced technology available.

Scott Bolton (Q-risq) said Q-risq essentially runs storm surge and wind velocity models prior to a storm making landfall. He said the data is then made available to individual addresses that are geocoded with a latitude and longitude, making the data specific to these individual addresses. Mr. Bolton said the dashboard in the Q-risq program also shows the overall impact to the customer. He said Q-risq is in the process of developing an app that provides data relevant to each address; this app provides updates every six hours as the NHC issues new advisories.

Mr. Bolton said, in a post-storm analysis, Q-risq does validation using National Oceanic and Atmospheric Administration (NOAA) and U.S. Geological Survey (USGS) observations, allowing Q-risq to match its model to actual observations after the
storm. He said this allows Q-risq to provide the information to municipalities, the federal government or to individual insurance companies to help validate what actually took place at specific addresses and help to expedite the closing of claims.

Mr. Case said Q-risq contacted the Mississippi Insurance Department (MID) last fall regarding its product and gave the MID the opportunity to use the product with Hurricane Zeta. He said a policyholder was denied coverage due to the fact Q-risq believed the damage to some of the properties was flood-related. Mr. Case said the MID worked with Q-risq and, within a day, there was a report with the data needed to show it was not a water loss, but in fact a wind loss, and the insurer reversed its decision.

Mr. Bradner said one of the concerns he would have regarding having individuals access this data and monitor the storm as it approaches is that individuals may think they are out of harm’s way according to the product and not evacuate when it might be necessary. He also asked how this related to Hurrevac, as many municipalities use Hurrevac to monitor and identify a storm path and where properties may be in harm’s way.

Mr. Bolton said Q-risq is using data issued by the NHC, so it is not doing predictive tracking. He said if there is a mass evacuation, Q-risq not contradicting this; it is simply producing a high-resolution model. Mr. Bolton said the Q-risq model does not just show an area that is going to receive an 8-to-10-foot storm surge, but how that surge is going to specifically impact an individual’s address with a surge above ground, not just above the sea level.

Elizabeth Valenti (Q-risq) said the Hurrevac product uses a storm surge model called SLOSH (Sea, Lake and Overland Surges from Hurricanes), which is a generalized model. Q-risq runs its model on a supercomputer, and it takes a couple of hours to run because Q-risq’s resolution is much higher than the SLOSH model. She said Hurrevac provides a general forecast, whereas the Q-risq tool provides a property-specific forecast, using light detection and ranging (LiDar)-derived digital elevation models. She said Q-risq takes the government products and post-processes them into the private market specific-use case.

Mr. Bradner asked if the new app is available for all jurisdictions or limited jurisdictions.

Ms. Valenti said the product works for all North American Atlantic basin, which includes the Eastern seaboard and the Gulf Coast for North American land-falling hurricanes.

Mr. Bolton said Q-risq has two different products. He said one is wind velocity and the other is storm surge. Mr. Bolton said storm surge is relative to a mesh, and a mesh is dictated by elevation. He said 10 meters above a mean sea level and 10 meters below a sea level are surge area and the wind velocity goes as far inland as the NHC continues to issue advisories.

Mr. Bolton said, with its wind analysis in a hind cast, Q-risq can report the maximum wind velocity at a particular location, as well as the direction and duration of the event.

Mr. Bolton said RMS is doing so-called “predictive destruction,” which Q-risq is looking into for its model. He said the Q-risq model currently does not include a prediction of damage ahead of landfall. Mr. Bolton said this is something Q-risq would like to produce, or possibly to work with modeling companies at some point in the future to provide. Mr. Bolton said if Q-risq is given coverage or the assessed value of an individual’s address, it can show the risk level; however, it has not started working on a predictive model for destruction.

4. **Heard Updates Regarding Recent Catastrophic Events**

   a. **Mississippi**

Mr. Case said the forecast models ahead of Hurricane Zeta showed it to be a Category 2 storm. He said these models were correct; however, the storm picked up speed as it made landfall and ended up being a lower-end Category 3 storm.

Mr. Case said there were roughly 24,000 residential property claims reported as a result of Hurricane Zeta, which resulted in $108 million in payments. He said there were also a significant number of claims closed without payment. The damage from this storm were primarily roof claims. Due to actual cash value (ACV) payments with holdbacks for depreciation, as well as named storm deductibles, payments were less than expected. Approximately 55% of the claims were closed without payment, meaning many policyholders did not have enough damage to reach their deductibles.
Mr. Case said, in addition to residential property claims, Mississippi had roughly 650 commercial property claims. These claims payments amounted to approximately $5 million. Commercial property claims closed without payments were a little less than 50%.

Mr. Case said personal auto claims were somewhat surprising, as this was mainly a wind event. He said there were more than 5,000 personal auto claims reported, resulting in claims payments of $24 million. Approximately 650 of these claims were closed without payment. Mr. Case said there were roughly 85 commercial auto claims reported, amounting in $400,000 in claims payments.

Mr. Case said the only complaints the MID received stem from some large commercial loss claims. He said, for the most part, the claim response following Hurricane Zeta has been good.

Mr. Bradner asked if Mr. Case had a sense as to whether 2% or 5% hurricane deductibles were used.

Mr. Case said the MID saw a representative number of deductibles at both 2% and 5%. He said in talking to consumers, there were a number of them that were unaware that they could buy that deductible down, per Mississippi statute.

Mr. Bradner asked if Mississippi had a provision in its law about multiple hurricane events and deductibles.

Mr. Case said Mississippi does not have a provision in its law regarding multiple hurricane events and deductibles. He said this has been discussed, as both Louisiana and Alabama have had multiple hurricane events this year. Mr. Case said Mississippi will be looking at this issue.

b. Alabama

Mr. Powell said Alabama had three storms that affected the state severely in 2020.

Mr. Powell said Tropical Storm Cristobal was basically a rain event. The storm passed through the state and saturated the ground. Shortly following Tropical Storm Cristobal, Alabama experienced its first and second hurricanes. The saturation from Tropical Storm Cristobal was the cause of a lot of flooding.

Mr. Powell said Alabama saw a lot of coastal and riverine flooding, but also experienced numerous trees falling due to the water saturation causing damage. The first hurricane did not cause a lot of wind damage; however, there was damage due to tree fall. Mr. Powell said the second hurricane was a wind event and mainly affected the central and northeastern part of the state. He said there are still a number of claims being filed due to the storm.

Mr. Powell said Alabama was faced with the deductible issue, as there is no mechanism to deal with multiple deductibles. He said there were parts of the state where insureds had significant damage to their homes or commercial business from the storm, and then a couple of weeks later another hurricane came through that did additional damage to the structures. Mr. Powell said Alabama is looking into a mechanism to deal with multiple deductibles, as it is going to be difficult for some policyholders to recover.

Mr. Powell said there were boats sitting in the middle of interstates and the state had problems finding the boats’ owners. He said the insurance industry responded to this problem and were able to get the boats towed and then worked to handle the claims with the boat owners.

c. California

Ms. Wehmueller said Moody’s identified the 2020 California wildfire season as having approximately 3 million acres burned, affecting 5,800 structures. This resulted in estimated losses of $4.8 billion. Ms. Wehmueller said 2020 was less damaging than previous years in terms of insured losses; however, there were more acres burned. She said, in contrast, the insured damage for 2017 and 2018 combined was $25 billion.

Ms. Wehmueller said the California Department of Insurance (CDI) Consumer Services Division assisted at approximately 16 local assistance centers to help insureds receive needed checks and contents advances, as well as to answer questions. Ms. Wehmueller said the CDI also did a demonstration for a virtual local assistance center due to the COVID-19 pandemic, so
consumers could speak to Consumer Services Division representatives virtually. She said the CDI had a positive experience with the virtual local assistance center and will explore using virtual local assistance centers in the future.

Ms. Wehmueller said the COVID-19 pandemic caused travel restrictions, as well as consumer fears about being involved on an in-person basis. Due to this issue, attendance at the local assistance centers was not as high as expected, given the number of wildfires that occurred during the year. Ms. Wehmueller said the CDI is in continuous talks with the California Governor’s Office of Emergency Services and FEMA to put in a plan for true virtual local assistance centers for future events. She said the CDI also used its Consumer Services Division hotline staff to assist consumers with insurance concerns.

Ms. Wehmueller said the CDI has kept its public website updated regarding wildfire resources that provide important notices the CDI has issued related to wildfires, as well as information regarding consumer rights and laws that specifically apply to the claims process. She said the CDI also has a Property Insurance Policy Locator tool, which helps survivors in the event that a property owner perishes in a wildfire. The legal representative may use the tool if the property is located in a declared disaster area.

d. Louisiana

Mr. Byrd said Louisiana experienced five storms in 2020.

The first storm experienced by Louisiana was Tropical Storm Cristobal. Residential losses were about $12.3 million, while commercial losses totaled $1.3 million. Mr. Byrd said a few months later, Hurricane Marco—which skirted the coast and was not declared a disaster—was, therefore, minimal in nature.

Mr. Byrd said, shortly after Hurricane Marco, Hurricane Laura hit. He said 170,000 claims resulted from this one storm. Residential losses totaled $3.3 billion and commercial losses totaled $3.4 billion, for a total of almost $7 billion in insured losses from this one event.

Mr. Byrd said Hurricane Delta hit in October and was the fourth storm to hit Louisiana in 2020. This storm produced 72,000 claims and, to date, there have been residential losses of $410 million and commercial losses of $150 million.

Mr. Byrd said, later in October, Hurricane Zeta hit, resulting in approximately 49,000 claims and causing residential losses of $230 million and commercial losses of $270 million.

Mr. Byrd said Louisiana also experienced an ice storm in 2021, and they are still working thorough this event. He said he did not have data to present today, but Louisiana does not generally experience three to four consecutive days of subfreezing temperatures.

Mr. Byrd said Commissioner James J. Donelon (LA) issued Emergency Rule 45 because of Hurricane Laura claims. He said the main complaint received regarding Hurricane Laura was the multitude of adjusters or the changing of adjusters by carriers, which resulted in a failure to pay or a late payment.

Mr. Byrd said the Louisiana Department of Insurance issued two bulletins, the first one being Bulletin 2021-02, which extends the proof of loss time frame from the normal 60 days to 180 days in the event of a catastrophe. The bulletin also describes how to calculate replacement cost coverage, especially on a room. He said the second bulletin issued was Bulletin 2021-03, which charges the industry with the duty of good faith and fair dealing with their policyholders. It also entitles policyholders to obtain a copy of their policy if they ask for it.

e. Texas

Mr. Worman said Texas experienced a winter storm Feb. 11–19, 2021. He said this event affected all 254 Texas counties. Mr. Worman said once the storm hit, the Texas Department of Insurance (TDI) extended its consumer help line hours, started to develop consumer information specific to the event (e.g., information regarding how to file claims, frequently asked questions, etc.) and worked with the Texas Department of Emergency Management to disseminate this information. Mr. Worman said the TDI has a storm resource page on its website. He said the TDI Public Affairs Department utilized social media to disseminate information to consumers.
Mr. Worman said the TDI issued several bulletins, just as it would after any catastrophic event. These bulletins reminded insurers of claims-handling deadlines and consumer protections related to underwriting, nonrenewals, credit scoring and other items. He said there are many policies that include provisions for freezing, so the TDI issued a bulletin regarding freezing. These items include the policyholder taking reasonable care to maintain heat or shut off water supply and drain pipes.

Mr. Worman said many things were beyond the control of the insured regarding this event, such as the frequency and length of power outages, that could have prevented many policyholders from maintaining heat in their homes. He said many consumers lost power for extended periods of time, while other consumers lost and had intermittent power. Mr. Worman said there are still consumers that do not have water. He said this bulletin was to inform insurers of the TDI’s expectations, as well as to consider the severity and nature of these events and to consider these factors when adjusting these claims.

Mr. Worman said there are two data-collection efforts underway. He said the TDI has issued a claims survey to some of the top writers in the state, which represents approximately 87% of the residential market and 80% of the commercial property market. The claims survey allows the TDI to collect information quickly on a statewide aggregate basis and includes information from licensed insurers. Information includes items such as the number of claims reported, the number of claims paid at the end of the month, and the number of claims open at the end of the month. Mr. Worman said this information is reported quickly, so it can be reported to the legislature, as the legislature is in session and has expressed interest in this information. The first submission is due March 12.

Mr. Worman said TDI has also activated its Catastrophe Event Statistical Plan for Personal and Commercial Risks. He said the reason the TDI is doing two data-collection efforts is that the catastrophe statistical plan is used to gather detailed information by ZIP code and it is not just to collect data from licensed insurers, but it is also to collect data from surplus lines insurers. This effort takes a little longer. He said the catastrophe statistical plan was activated Feb. 26 and insurers are required to submit the first round of data by March 31. Insurers are required to file monthly thereafter.

Commissioner Chaney said the NAIC is creating a website that is intended to be a “one-stop shop” for state insurance regulators that will contain resources pertaining to catastrophes. The website will house everything from bulletins, to regulator resources, to consumer resources for regulators to use. The website will also have links to federal information regarding catastrophic events, such as FEMA resources. This information will be shared in more detail during the Property and Casualty Insurance (C) Committee meeting during the Spring National Meeting. As the NAIC posts this information, input and suggestions from state insurance regulators are welcome.

Having no further business, the Catastrophe Insurance (C) Working Group adjourned.
The Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met Nov. 17, 2020. The following Working Group members participated: Mike Chaney, Chair, and Andy Case (MS); Robert X. Lee, Vice Chair, and Virginia Christy (FL); Brian Powell and Willard Smith (AL); Katie Hegland (AK); Lynne Wehmuller (CA); George Bradner (CT); Colin M. Hayashida (HI); Travis Grassel (IA); Robert Rapp (IL); Brenda Johnson (KS); Warren Byrd (LA); Matthew Mancini (MA); Joy Hatchette (MD); Jeana Thomas (MO); Kelly Ricketts (Smith) (NC); Carl Sornson (NJ); Tom Botsko (OH); Cuc Nguyen and Andrew Schallhorn (OK); Beth Vollucci (RI); and Marianne Baker, J’ne Byckovski and Mark Worman (TX). Also participating was: Donna Stewart (WY).

1. Heard an Update Regarding Federal Legislation

Brooke Stringer (NAIC) said the National Flood Insurance Program (NFIP) is operating on a one-year extension through Sept. 30, 2021. This is the 16th short-term extension of the NFIP since the 2017 expiration of the program, but this is the longest of those extensions. Ms. Stringer said it will be up to the next U.S. Congress, which officially convenes in January 2021, to decide how to address a long-term reauthorization. She said that given the COVID-19 pandemic and other competing priorities, as well as the one-year extension, NFIP reauthorization is unlikely to be one of the top priorities at the beginning of the new Congress. She said it is likely that the same debates will come up again over whether more private insurers should take over, affordably, rebuilding repetitively flooded homes.

Ms. Stringer said that on Nov. 10, the U.S. Department of Housing and Urban Development (HUD) released a proposed amendment to Federal Housing Administration (FHA) regulations that would allow lenders to accept private flood insurance policies on FHA-insured properties located in Special Flood Hazard Areas (SFHAs). She said this is noteworthy, as the FHA’s current rules do not allow private flood insurance to satisfy the mandatory purchase requirement.

Ms. Stringer said that the proposed rule would amend FHA regulations to include the definition of “private flood insurance” from the federal Biggert-Waters Flood Insurance Reform Act of 2012 (Biggert-Waters Act). It also includes a “compliance aid” allowing mortgagees to accept private policies, without further review, where the policy or an endorsement includes the language: “This policy meets the definition of private flood insurance contained in 24 CFR 203.16a(e) for FHA-insured mortgages.” She said the proposed rule also says it “will not permit Mortgagees to exercise their discretion to accept flood insurance policies, provided by private insurers or mutual aid societies, that do not meet the definition and requirements for a private flood insurance policy as laid out in this rule.”

Ms. Stringer said that because of the differences between HUD and the federal banking regulators’ rules, compliance with the banking rule will not be interpreted as compliance with HUD’s requirements. She said HUD will accept comments for 60 days following the date of the proposed rule.

Mr. Byrd said he read something a few days ago in an article where the author suggested property developers developing property in areas presumed to be at sea level upon completion should not be allowed to obtain flood insurance. Not allowing flood insurance would be used as a way to prevent developers from developing in areas that might potentially soon be flood-prone areas. He asked if there has been any traction for this type of legislation in Congress.

Ms. Stringer said that with the incoming administration, there will likely be more of a focus on issues related to climate risk and resiliency. She said there will likely be more action at the federal regulatory level in the next four years too. Ms. Stringer said Congress is getting close to the end of the session, but she believes there will be more action at the federal regulatory level than in the past couple of years.

Mr. Bradner asked where Federal Emergency Management Agency (FEMA) stands regarding Risk Rating 2.0 and asked if it was still on schedule for 2021. He also asked if states would be provided with data so states would know how it is going to affect home property owners in their respective states.
Ms. Stringer said this is a good question and that she believes it was set to go into effect in October 2021. She said she is not sure if there will be any changes that will take place due to the incoming administration. Ms. Stringer said Congress has shown some concern regarding Risk Rating 2.0.

Jeffrey Klein (Consumer Representative) said he was on the Southeast State Emergency Response Agency (SERA) meeting a couple of weeks ago and heard from Tony Hake (FEMA). Mr. Hake said FEMA was planning to roll out training for state insurance regulators, realtors, banks and others sometime in early 2021.

Commissioner Chaney said he is also hearing that FEMA may enact a regulation to raise the sea level requirement, so it does not have to go through Congress to be eligible to write flood insurance through the NFIP. He said this is what FEMA does in counties and parishes throughout the country.

2. Discussed NAIC/FEMA Regional Meetings Held with Various Regions

Commissioner Chaney said the NAIC has been partnering with FEMA and holding joint meetings in various regions to present a better understanding of the flood event response process and to discuss ways in which FEMA and state departments of insurance (DOIs) can better coordinate in this process. He said, to date, the NAIC and FEMA have held events with FEMA Region 7 states and FEMA Region 4 states. The NAIC and FEMA will hold another event in January 2021 with FEMA Region 8, FEMA Region 9 and FEMA Region 10 states. Commissioner Chaney said these events have transitioned to virtual events as a result of the pandemic.

Jeff Czajkowski (NAIC Center for Insurance Policy and Research—CIPR) said the joint meetings with the NAIC and FEMA in 2020 will continue into 2021. He said the purpose for the roundtables is to make recommendations and to discuss solutions related to insuring for catastrophe risk. These roundtables discuss ways in which the NAIC can assist states in responding to disasters.

Mr. Czajkowski said that in January 2020 that the NAIC and FEMA held a forum with FEMA Region 7, which includes Iowa, Kansas, Missouri and Nebraska; this roundtable was organized in the aftermath of the 2019 Midwest flooding. The second roundtable was held with FEMA Region 4, which includes the eight Southeast zone states. He said the discussion at the second roundtable was centered on the possibility of an active hurricane season, as well as incorporating issues regarding how the response might be different due to the COVID-19 pandemic. Mr. Czajkowski said while the goals were similar, the topics of discussion were different. He said highlighting the NAIC Disaster Assistance Program was an important part of the discussions that took place.

Mr. Czajkowski said the roundtables also highlighted best practices that some of the state DOIs have put into place during a catastrophic event. These discussions helped other states, as well as FEMA, learn from each other. He said part of the goal was to make sure the states understand FEMA’s response at both the regional and federal level and what the touchpoints are for the states. The roundtable focused on the before, during and after aspects of a catastrophic event.

Mr. Czajkowski said part of the purpose of these events was to begin laying or expanding the relationship between FEMA and the states. He said many of these states have already established a relationship with FEMA. He said the states and FEMA were both able to share resources available. He said the states and FEMA also found some areas to collaborate on in the future.

Mr. Czajkowski said some of the topics discussed are geared toward: 1) how the NFIP and the private marketplace can work together moving forward; and 2) how FEMA and the NAIC can collaborate on messaging around flood insurance and mitigation. He said, from a research perspective, the roundtable highlighted some academic outreach; for example, the University of Iowa and its Iowa Flood Center was introduced to the state insurance regulators.

Mr. Czajkowski said a memorandum of agreement with schema has been formulated that allows for future partnership building to take place at the regional level as state DOIs and FEMA see fit. He said FEMA Region 4 states and FEMA were interested in forming a disaster resiliency working group within that region. This allows the states and FEMA to collaborate on resiliency moving forward. Mr. Czajkowski said the next roundtable will be held with FEMA Region 8, Region 9 and Region 10 and will focus on wildfire and earthquake.

Mr. Czajkowski said that in early 2021, he will begin to work on some long-term planning around mitigation funding.
3. **Discussed Hurricane Response During This Year’s Hurricane Season**

Commissioner Chaney said this year has been a highly active hurricane season; as a matter of fact, 2020 now officially has had the most named storms on record. This hurricane season brings twice the usual number of storms. Five of these storms have become named hurricanes as of Nov. 15. Iota became the 30th named storm and made landfall in Central America. This storm is extremely dangerous.

Commissioner Chaney said many residents in the Gulf states have suffered considerable losses this year. He said the Working Group will hear from Alabama, Louisiana and Mississippi about their experiences this year. Commissioner Chaney said he realizes other states have also experienced devastation from hurricanes this year and asked them to speak up and add their experiences during these discussions.

Commissioner Chaney said the Working Group also realizes there have been many devastating wildfire events across the U.S. and would like to meet a month following the Fall National Meeting to discuss this peril.

a. **Alabama**

Mr. Powell said this was a busy year for Alabama as far as the hurricane season was concerned. He said Alabama is fairly well prepared for hurricanes, and the industry responded well to the multiple storms that occurred. Mr. Powell said the storms took different tracks as they came through Alabama, so the damage was spread throughout the state, although there were some areas where damage was overlapping. He said the areas where the damage overlaps between more than one storm caused more issues than other areas.

Mr. Powell said Hurricane Sally caused a lot of flooding and flood damage. He said the second storm to hit was Hurricane Zeta, which was a fast-moving hurricane that caused widespread wind damage.

Mr. Powell said Alabama used the NAIC for data collection following the storms. He said this was the first year they used NAIC services, and they were happy with the assistance they have received.

Mr. Powell said one of the challenges faced in Alabama is the multiple deductible issue they are faced with due to multiple storms. He said Alabama does not have a mechanism in place to address the multiple deductible issue. Mr. Powell said multiple deductible issues were seen in the areas where storm paths overlapped, and storm damage occurred from multiple storms that occurred in fairly quick succession. He said Alabama does not have a mechanism in place for handling multiple deductibles, such as a seasonal deductible, or something of that nature, which caused some issues for some policyholders.

Mr. Powell asked for other states to share suggestions or ideas regarding what mechanisms states might have in place.

Mr. Bradner said Florida and Rhode Island have legislation in place that addresses how multiple named storms can be addressed so that the consumer is not affected as greatly.

Ms. Vollucci said Rhode Island has a requirement that hurricane deductibles are only allowed to be charged once in full per each policy term. She said for damages other than hurricane, policyholders are charged their regular deductible.

b. **Louisiana**

Commissioner Donelon said that in 2009, Louisiana experienced two hurricanes, Gustaf and Ike, within a three-week period.

He said that in 2008, Louisiana had reached out to Florida and used the legislation they had passed in the aftermath of four storms they experienced in 2004. He said the legislation in Louisiana applies a single hurricane named storm and wind/hail deductible per hurricane season. He said if a policyholder does not exhaust the named storm deductible with the first event, the remainder carries over to the second hurricane event. He said once the hurricane deductible is met, the all-perils policy deductible kicks in.

Commissioner Donelon said this year, there are a couple of insurers that have announced they will waive any deductible for the second hurricane event for damage occurring from Hurricane Delta.
Commissioner Chaney asked if the deductible accumulation applies to roofs. Commissioner Donelon said it applies to any damage.

Mr. Byrd said Louisiana gets claim reporting from FEMA on a regular basis for the three hurricanes that have caused flood events this year.

c. Mississippi

Mr. Case said Mississippi was also affected by Hurricane Zeta. He said Mississippi experienced more wind damage than what was expected. Mr. Case said Mississippi had a forecast surge of 9 feet in some areas, and the forecast was accurate. He said the surge exceeded 11 feet in some areas.

Mr. Case said Mississippi staff members traveled 60 miles of coastline after the storm, and virtually no property was untouched. He said much of the damage was not considered major, and there were many claims filed below the policyholder’s deductible.

Mr. Case said there are roughly 18,000 claims reported to date, and 60% of those claims have been closed without payment. He said through Nov. 6, there has been roughly $14 million paid in residential losses; however, this is only on roughly 25% of the reported claims being closed to date.

Mr. Case said that the personal auto claims reported were 80% less than the property claims, yet the paid loss on auto is nearly half of the paid losses on the property claims.

Mr. Case said there are less than 300 claims reported on commercial losses. He said the number of claims closed is probably a 2:1 ratio of those claims that are closed. The current commercial losses paid are currently less than $500,000. However, less than 50% of those claims have closed to date.

Mr. Case said the insurance response has been robust, and they are currently seeing some price gouging. He said there are some out-of-state roofers and out-of-state tree services charging for unnecessary equipment. Mr. Case said there are some contractors out of Florida that are attempting to obtain assignment of benefits, which are not recognized in Mississippi, so they are working closely with the attorney general’s office for some assistance on those issues.

Mr. Case said the insurance department is currently dealing with a number of inquiries and concerns regarding the named storm deductibles. He said some consumers are not quite understanding these deductibles when they purchase the policy, as well as not understanding that by Mississippi statute, they are able to buy down the deductible. Mr. Case said the insurance department is providing a lot of education and coaching on this issue.

Mr. Case said Mississippi had a number of wind pool policies that were underinsured. He said the wind pool worked with policyholders previously to make sure they were paid at a replacement cost level. Mr. Case said Mississippi made some statutory changes to allow the wind pool to make sure policyholders are insured for at least 100% to replacement cost value. He said the idea behind this was that they did not want a storm coming through that resulted in a bunch of actual cash value (ACV) policies.

Mr. Smith asked if someone from Louisiana would discuss suspension of cancellation of a policy during the time an emergency rule is in effect due to a hurricane.

Mr. Byrd said Emergency Rule 45 deals with Hurricane Laura and stated that from the day the emergency rule was issued, if a cancellation had not gone into effect, then the insurer had to remain on the risk during the emergency rule. He said once the emergency rule lifts, an insurer can reissue a nonrenewal or cancellation. Policyholders are still obligated to pay their premium. However, policyholders should pay their premium during the emergency rule if they are able to because the premium will come due.

Commissioner Chaney said it might be worthwhile to collect information on the practices of the various DOIs during the hurricane season.

Having no further business, the Catastrophe Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee conducted an e-vote that concluded April 8, 2021. The following Working Group members participated: Don Beatty, Chair (VA); Kendra Zoller, Vice Chair (CA); George Bradner (CT); Shirley Corbin (MD); LeAnn Cox (MO); Erin Summers (NV); Michael McKenney (PA); Matt Gendron (RI); Kathy Stajduhar (UT); and David Forte (WA).

1. **Adopted its March 26 Minutes**

The Working Group conducted an e-vote to consider adoption of its March 26 minutes (Attachment Three-A). The motion passed with a majority of the Working Group members voting in favor of adopting the minutes.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met March 26, 2021. The following Working Group members participated: Don Beatty, Chair, Jessica Baggarley and Phyllis Oates (VA); Kendra Zoller, Vice Chair, and Risa Salat-Kolm (CA); Katie Hegland (AK); Kristin Fabian and George Bradner (CT); Angela King (DC); Warren Byrd (LA); Rasheda Chairs, Shirley Corbin, and Linas Glemza (MD); Carrie Couch, LeAnn Cox and Jeana Thomas (MO); Erin Summers (NV); Michael McKenney (PA); Elizabeth Kelleher Dwyer and Matt Gendron (RI); Anna Van Fleet (VT); and David Forte and Eric Slavich (WA). Also participating were: Elizabeth Perri (AS); Heather Droge and Brenda Johnson (KS); Tracy Burns (NE); Maggie Dell (SD); and Jody Ullman (WI).

1. **Adopted its March 4 Minutes**

The Working Group met March 4 to discuss Section 3D of the draft Pet Insurance Model Act.

Mr. Byrd made a motion, seconded by Mr. Gendron, to adopt the Working Group’s March 4 minutes (Attachment Three-A1). The motion passed unanimously.

2. **Discussed Section 7A and Section 7B of the Draft Pet Insurance Model Act**

Mr. Beatty said the Working Group had received proposed language from the North American Pet Health Insurance Association (NAPHIA) and the American Veterinary Medical Association (AVMA) to be added on to the current language in Section 7A. That language reads: “The insurer has the burden of proving the preexisting condition exclusion applies to the condition for which the claim is being made.” Mr. Gendron said the language was pro-consumer and that it made sense for the insurer to have the burden of proving the exclusion. Mr. Forte agreed and said the language would help avoid confusion. Birny Birnbaum (Center for Economic Justice—CEJ) said the language is good for the consumer, but it is unclear why the language is necessary because it should be given that the insurer would have to prove why the claim is being denied. Mr. Byrd said this language makes it clear that the insurer has the burden. Isham Jones (AVMA) said it is important to have clarity about who has the burden of proof and said that language does not exist anywhere else in the model. Kate Jensen (NAPHIA) said the current standard practice is that the insurer has the burden of proof, and this language reiterates that and provides comfortability to all stakeholders.

Mr. Birnbaum said the language in Section 7A is confusing and repetitive. He said Section 7 should include standards for what constitutes a legitimate preexisting condition provision. He suggested using language such as: “Any policy provision or disclosure for preexisting may not be obscure, misleading, deceptive or unfair.” Ms. Jensen said the standard is reflected in the definition of “preexisting condition” found in Section 3. She said there would not be a problem including language that disclosures cannot be unfair, deceptive or misleading, but those rules already exist in the unfair trade practices statutes. Lisa Brown (American Property Casualty Insurance Association—APCIA) said that pet insurance is a property/casualty (P/C) insurance product and that the model should avoid terms and considerations for the product that would be more appropriate for health insurance.

Mr. Forte made a motion, seconded by Mr. McKenney, to adopt the additional language for Section 7A as submitted by NAPHIA and the AVMA. The motion passed unanimously.

Mr. McKenney said the wording in Section 7B does not clearly state that it is referring to premium related to excluded coverage. He said he is not comfortable with the language as written. Mr. Gendron said he understands the concern, from an actuarial standpoint, of offering coverage without a cost. Mr. McKenney asked if industry would be concerned that the language reads as though a premium cannot be charged at all during a waiting period. Mr. Birnbaum said it is difficult to understand the concept of selling a product in which you must wait 30 days for coverage.

Ms. Jensen said as currently written, Section 7B: 1) would not allow insurers to have both waiting periods and preexisting condition exclusions; 2) has a 30-day limit on waiting periods; and 3) has a component that does not allow for premium to be charged during the waiting period. She said from NAPHIA’s perspective, these issues are problematic and will drive up the cost of pet insurance products. She said NAPHIA recommends striking the language in 7B and replacing it with language that
Discussed Policy Renewals as They Relate to the Draft Pet Insurance Model Act

Mr. McKenney proposed additional language to Section 3 to clarify how preexisting conditions are treated in renewal policies. He suggested adding to Section 3E—Pre-Existing Condition: “A condition for which coverage is afforded on a policy cannot be considered a preexisting condition on any renewal of the policy” and adding to Section 3H—Waiting Period: “A condition for which coverage is afforded on a policy cannot be excluded within a waiting period on any renewal of the policy.” He also suggested adding a new definition as Section 3I—Renewal that reads: “means to issue and deliver at the end of an insurance policy period a policy which supersedes a policy previously issued and delivered by the same insurer or affiliated insurer and there have been no consumer complaints around waiting periods. Mr. McKenney made a motion, seconded by Mr. Forte to adopt the proposed language for Section 3E—Pre-Existing Condition, Section 3H—Waiting Period and Section 3I—Renewal. The motion passed unanimously.

4. Discussed Unresolved Issues Within the Draft Pet Insurance Model Act

Mr. Beatty said there was discussion of inserting language in Section 3 that definitions should be substantially similar but not less favorable to those in the model. Ms. Brown said APCIA members think that their current policy definitions line up...
substantively with the definitions in the model and that they should not have to rewrite and refile their policies. She said she thinks the idea of using substantially similar language lines up with other NAIC models. Brendan Bridgeland (Center for Insurance Research—CIR) said there should be a standard as to what is substantially similar.

Mr. Beatty said there was discussion about expanding the definition of “chronic condition.” Mr. Forte said he had an issue with the word “chronic.” He said it is being used to mean incurable and asked if the AVMA had a perspective on the use of the word “chronic.” Dr. Gail Golab (AVMA) said they are comfortable with the use of the word “chronic” in the definitions. She said the current definition is applicable to most cases she has come across.

5. **Discussed Other Matters Affecting the Working Group**

Superintendent Dwyer said there are companies marketing wellness plans as non-insurance products that cover things that would normally be considered part of an insurance policy, such as wellness visits and spaying and neutering. She said the way they are marketed could be misleading to consumers. She said the Working Group should consider addressing this in the model.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met March 4, 2021. The following Working Group members participated: Don Beatty, Chair, Jessica Baggarley and Phyllis Oates (VA); Kendra Zoller, Vice Chair, and Risa Salat-Kolm (CA); Katie Hegland (AK); Kristin Fabian and George Bradner (CT); Warren Byrd (LA); Rasheda Chairs and Shirley Corbin (MD); LeAnn Cox and Kendra Hetland (MO); Erin Summers (NV); Mike McKenney (PA); Elizabeth Kelleher Dwyer and Matt Gendron (RI); Kathy Stajduhar (UT); Jamie Gile and Anna Van Fleet (VT); and David Forte, John Haworth and Eric Slavich (WA). Also participating were: Ken Williamson (AL); Vincent Gosz (AZ); Heather Droge and Brenda Johnson (KS); Chris Aufenthie (ND); Maggie Dell (SD); and Jody Ullman (WI).

1. **Adopted its Feb. 18 Minutes**

The Working Group met Feb. 18 to discuss Section 7 and Section 8 of the proposed Pet Insurance Model Act.

Mr. Byrd made a motion, seconded by Mr. Bradner, to adopt the Working Group’s Feb. 18 minutes (Attachment Three-A1a). The motion passed unanimously.

2. **Discussed Section 3D of the Draft Pet Insurance Model Act**

Mr. Beatty said the North American Pet Health Insurance Association (NAPHIA) and the American Veterinary Medical Association (AVMA) submitted language for the definition of “pre-existing condition” that was agreeable to both parties. Kate Jensen (NAPHIA) said the new language addresses questions about technical terms that came up on prior Working Group calls, and the new language also tightens the definition of what could be considered a pre-existing condition. She said the new definition inserts a clause about verifiable sources that allows sources beyond the pet’s medical record to be used to verify a pre-existing condition. She said the new definition includes the word “directly” inserted before “related to the condition” because the connection between the reported signs and symptoms and the condition for which the claim is being filed needs to be discernable. She said NAPHIA and the AVMA also submitted language related to pre-existing conditions to be used in Section 7A of the Pet Insurance Model Act that the burden is on the insurance company to prove that a pre-existing condition exclusion would apply. Isham Jones (AVMA) said the new proposed language better protects pet health, and the AVMA stands behind the language as submitted.

Mr. Forte said Washington is favorable to the new language. He asked for an example of a verifiable source of a symptom that would be directly related to a condition, and he asked why the term “symptoms” was included. Ms. Jensen said an example would be records from a shelter where a pet was adopted or information provided by the pet owner at the time of application for insurance. She said insurers could also use social media as a verifiable source of information relating to the pre-existing condition. Ms. Jensen said the term “symptoms” was included because it is consumer friendly and has been working in current California law. Mr. Gendron said the new language solves the problem of using the term “clinical signs” and the issues that would come up with having to define that term. He said the widely used definition of “symptom” makes sense in the context of this model.

Mr. Byrd asked whether there needs to be a temporal aspect to the three parts of the proposed definition to make it clear that previous veterinary advice does not preclude coverage for a current pet health condition. Dr. Jules Benson (NAPHIA) said the insertion of the term “directly related to” in the third part of the definition solves that problem. Mr. Byrd asked if there should be a temporal aspect in parts one and two of the definition. Dr. Benson said those parts of the definition deal directly with the advice and treatment of the stated condition, so there would not be a temporal issue with those parts.

Mr. Gendron asked whether a dog spraining a ligament three years ago and then spraining it again years later would be considered a pre-existing condition by the treating veterinarian. Dr. Gail Golab (AVMA) said re-injuring something that was already injured would be considered a pre-existing condition. Dr. Benson agreed that in this specific case, that injury would not fully heal, and a re-injury would be directly related to the previous injury. Mr. Gendron asked if the same logic would apply to a broken bone. Dr. Benson said if the bone broke in a different location and the break is not due to a weakness in the bone caused by the previous break, it would not be considered directly related to a pre-existing condition. Dr. Golab said the insertion of the “directly related to” language helps all parties understand that a clinical sign, even if presented exactly the same as in a...
past condition, cannot be used to justify a pre-existing condition if it is not directly related to the current condition for which treatment is being sought.

Ms. Salat-Kolm asked if pet insurers are currently using social media as a verifiable source for claims information. Dr. Benson said 99% of the time, information will come from the medical record. He said social media may be used in a case where a consumer reports an injury or illness close to the start of the policy to verify that the dog was healthy before the start of the policy. Mr. Bradner said insurers are already using social media to verify claims in other lines of business, like workers’ compensation. He said insurers would most likely use social media if there were suspicion of fraud.

Ms. Fabian asked how insurers would be provided with the language and the intent of the specific language being used within the model. Mr. Gendron said after the model is adopted by each state, there will sometimes be a model bulletin that can help clarify some of the language. Ms. Jensen said when the model is taken up by state legislation, there is an opportunity for the industry to participate in legislative hearings. She said NAPHIA represents 95% of pet insurance products, and a part of its mission for its members is education on regulatory issues.

Mr. Forte asked if an injury in a previous coverage period would be considered pre-existing in the renewal period. Dr. Benson said all policies on the market today include language that any subsequent policy period is a continuation of the first policy, and new pre-existing conditions do not apply to the language found in the first policy. He said there have been some policy types that state that each coverage term, the policy will start over as a new policy. He said this varies by product, and the same company can have different products that treat the renewal term differently in order to offer different policy price points. Mr. McKenney said if a pre-existing condition gets reset at a policy renewal, there should be language stating that in the disclosures. He asked if industry’s intent with the disclosures was to have them apply to both new and renewal policies. Ms. Jensen said NAPHIA would have no problem with more frequent disclosures if they include meaningful and helpful information to consumers. Mr. McKenney said a renewal policy not offering continuous coverage would violate the definition of renewal in Pennsylvania, and that type of policy would not be consumer friendly.

Ms. Dell asked if current policy language would allow for renewal of the policy if a veterinarian recommended euthanasia and whether the condition would then be treated as a pre-existing condition. Dr. Benson said to his knowledge, the recommendation of euthanasia would not change any of the coverage as it exists in the policy.

Brendan Bridgeland (Center for Insurance Research—CIR) said the term “verifiable sources” gives some cause for concern. He said if a condition is listed in a shelter record but the consumer was not aware of that condition prior to adopting the pet and applying for pet insurance, that shelter record could still be used against the applicant. He said while he understands the use of social media to prevent fraud in claims, there could be false information posted to social media that could be used as verifiable information. He suggested adding a drafting note to provide examples of verifiable sources. Mr. Beatty asked Mr. Bridgeland to submit language for the drafting note to the Working Group.

Mr. Gendron made a motion, seconded by Mr. Byrd, to adopt the proposed definition of pre-existing condition that reads:

“Pre-existing condition” means any condition for which any of the following are true prior to the effective date of a pet insurance policy or during any waiting period:

i. A veterinarian provided medical advice.
ii. The pet received previous treatment.
iii. Based on information from verifiable sources, the pet had signs or symptoms directly related to the condition for which a claim is being made.

The motion passed unanimously.

The Working Group agreed to look further into the issue of how renewal policies are treated and whether language requiring the treatment of renewal policies should be added to the draft model on a future call.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group met Feb. 18, 2021. The following Working Group members participated: Don Beatty, Chair, Jessica Baggarley and Phyllis Oates (VA); Kendra Zoller, Vice Chair, and Risa Salat-Kolm (CA); Katie Hegland (AK); Kristin Fabian and George Bradner (CT); Angela King (DC); Warren Byrd (LA); Sheri Cullen (MA); Rasheda Chairs, Shirley Corbin and Linas Glemza (MD); Carrie Couch, LeAnn Cox and Jeana Thomas (MO); Mike McKenney (PA); Matt Gendron (RI); Kathy Stajduhar (UT); Anna Van Fleet (VT) and David Forte, John Haworth and Eric Slavich (WA). Also participating were: Ken Williamson (AL); Michele MacKenzie (ID); Heather Droge and Brenda Johnson (KS); Daniel Lawson (ME); Chris Aufenthie (ND); and Jody Ullman (WI).

1. Discussed Section 7 and Section 8 of the Draft Pet Insurance Model Act

Mr. Beatty asked a representative from the American Veterinary Medical Association (AVMA) to speak to its submitted comments regarding the definition of “preexisting condition” as they related to Section 7. Dr. Gail Golab (AVMA) said the AVMA is pleased with the use of “contemporaneous” in the definition of “preexisting condition,” but he said the AVMA would like to see “and contemporaneous” used instead of the current “or contemporaneous.” She said the reason for the requested change is to make sure that “related” and “contemporaneous” were congruent. Dr. Golab said the AVMA believes that both conditions need to be present in order for the clinical signs to be appropriately associated with a particular animal’s condition. Mr. Beatty asked for the AVMA’s thoughts on the proposed definition from the North American Pet Health Association (NAPHIA). Dr. Golab said the AVMA continues to believe that “contemporaneous” is appropriate. She said the AVMA understands NAPHIA’s concern about the use of the term “clinical signs.” However, she said there is a concern that an animal could exhibit a clinical sign that may be related to multiple conditions during the animal’s lifetime and coverage should not be denied because an animal exhibits the same clinical sign for different conditions at different periods. Kate Jensen (NAPHIA) said the signs of some conditions do wax and wane, so the use of “contemporaneous” is not appropriate because it is not an accurate indicator of what may be going on with a pet at any given time. Mr. Beatty asked if the average consumer would understand a claim denial based on the “contemporaneous” language. Ms. Jensen said “contemporaneous” is not common terminology for the consumer. She said California has not had a problem administering its pet insurance law and its definition of “preexisting condition,” which does not include “contemporaneous.” She said the California law seems to be working well for both the California Department of Insurance (DOI) and consumers.

Mr. Gendron asked if it is possible to remove the word “clinical” from the “preexisting condition” definition. Dr. Golab said the previous discussion of the inclusion of “clinical sign” was related to the difference between a clinical sign and a symptom. She said symptoms are self-reported and do not exist in the world of veterinary medicine. She said the use of “clinical sign” allows for observation by both the owner and in a veterinarian’s exam room. She said the proposed AVMA definition is more supportive of both the consumer and the veterinarian because it reduces the number of claims that should potentially be denied. Ms. Jensen said NAPHIA is willing to withdraw its proposed definition of “clinical signs” in order to eliminate confusion on the part of the consumer. She said NAPHIA members have not had a difficult time administering the current California language that reads “signs or symptoms.” Brendan Bridgeland (Center for Insurance Research—CIR) said from a consumer perspective, the term “clinical” is problematic as it could be read to mean that it has been diagnosed by a professional.

Ms. King said from a consumer perspective, the meaning of “signs and symptoms” needs to be clear in order to understand what would be covered in a claim.

Mr. Byrd asked if a veterinarian gave advice on how to keep a dog healthy, and later on the dog developed an issue related to something the veterinarian previously discussed with the consumer, would the claim for treatment be denied. Jules Benson (NAPHIA) said the burden of proof is on the insurer to say that there is a connection to anything that happened before the policy and what is happening with the pet during the policy. He said with respect to Mr. Byrd’s example, an insurer would not be able to deny that claim.

Mr. Benson said this line of insurance is extremely open to adverse selection. He said people can buy pet insurance, knowing something is wrong with their pet but not having been to the veterinarian. Once the policy is in force, he said the consumer could report that his or her pet had had a certain clinical sign for some time. He said that the observations by pet owners and clinicians is used to build the clinical picture of the pet’s health. Mr. Benson said pet insurers have veterinarians on staff to
analyze medical records in order to prove beyond a doubt that a clinical sign is part of a preexisting condition. Mr. Byrd asked where the line is between clinical advice and diagnosis. Mr. Benson said advice about preventative care is not a clinical diagnosis.

Mr. Bradner said it is important to include language that prevents a situation where clinical signs that presented a year ago are not wrongly connected to clinical signs or a diagnosis in the future. He said he thinks “contemporaneous” or language with the same meaning should be included in the definition. Mr. McKenney and Ms. Van Fleet agreed that the definition should guard against the situation described by Mr. Bradner and others. Mr. Forte said the definition could include a statement that it is the burden of the insurer to prove the preexisting condition.

Mr. Beatty said NAPHIA and the AVMA will work together to come up with a compromise on the definition of “preexisting condition” to the Working Group.

Ms. Jensen said for Section 7B, NAPHIA has surveyed its members and found virtually no consumer issues with waiting periods. She said to keep the model from becoming too prescriptive, it would be better to rely on the disclosure requirements for waiting periods found in Section 4 of the model and allow for flexibility with policy structure within Section 7B.

Mr. Byrd asked if the language in Section 7B allows a company to employ a 30-day waiting period but choose to offer coverage during that period. Ms. Jensen said NAPHIA would like to allow for flexibility in the length of a waiting period. She said different companies and policies currently employ their waiting periods differently based on condition. She said waiting periods tend to be longer for conditions that take longer to manifest in pets—for example, joint issues. She said flexibility already exists in the marketplace, and consumers seem to like that. Mr. Byrd asked if a mandated waiting period would do away with the preexisting condition clause. Ms. Jensen said the waiting period and preexisting condition clause should work in tandem and are used to be fair to consumers with a healthy pet. She said NAPHIA is trying to eliminate the opportunity for someone with a very sick pet to get coverage after they know the pet is sick and, in turn, drive up the cost of policies for everyone. Ms. Fabian asked if an accident occurred during the waiting period that resulted in an injury, would that injury be covered. Mr. Benson said it would not be covered. Mr. Gendron said there should be a better balance in the allowable waiting period time and that disclosures would not be a reasonable alternative if enough consumers were not thoroughly reading their policies. Mr. Byrd asked if a pre-policy veterinary examination of the pet could get rid of a waiting period. Mr. Benson said that while some companies have implemented an examination requirement to waive the waiting period, it could be a barrier to adoption because of the time and cost to the consumer for the exam.

Mr. Beatty said the Working Group had previous discussions on the language in Section 8 with regard to reimbursement of covered expenses. Mr. Byrd and Ms. Jensen said the reimbursement requirements and notices are appropriately covered in Section 4C and Section 4D.

Mr. McKenney made a motion, seconded by Mr. Gendron to remove Section 8 from the model. The motion passed unanimously.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Transparency and Readability of Consumer Information (C) Working Group of the Property and Casualty Insurance (C) Committee met March 15, 2021. The following Working Group members participated: Joy Hatchette, Chair, and Jimmy Gunn (AL); Ken Allen (CA); Bobbie Baca (CO); George Bradner (CT); Angela King (DC); Robert Rapp (IL); Heather Droge, Tate Flott and Brenda Johnson (KS); Ron Henderson (LA); Daniel Bryden (MN); Carrie Couch, Kendra Hetland, Jo LeDuc and Jeana Thomas (MO); Kathy Shortt (NC); Chris Aufenthie (ND); Cuc Nguyen (OK); Brett Bache (RI); David Combs, Jennifer Ramcharan and Vickie Trice (TN); Marianne Baker, Laura Machado and Mark Worman (TX); and Dena Wildman (WV). Also participating were: Kate Kixmiller (IN); Renee Campbell (MI); Jana Jarrett (OH); Tracy Klausmeier (UT); Katie Humphrey (VT); Josh Culley and Manabu Mizushima (WA); Diane Dambach and Darcy Paskey (WI); and Tana Howard (WY).

1. **Adopted its Feb. 4, 2021, and Nov. 17, 2020, Minutes**

The Working Group met Feb. 4, 2021, and Nov. 17, 2020, to discuss the need for consumer disclosures regarding significant premium increases on property/casualty (P/C) insurance products.

The Working Group also conducted an e-vote that concluded Nov. 23, 2020, to adopt its Oct. 29, Oct. 13 and Sept. 21, 2020, minutes (see NAIC Proceedings – Fall 2020, Property and Casualty Insurance (C) Committee, Attachment Five).

Ms. Droge made a motion, seconded by Ms. Couch to adopt the Working Group’s Feb. 4, 2021 (Attachment Four-A) and Nov. 17, 2020 (Attachment Four-B) minutes. The motion passed.

2. **Discussed a Work Plan for Drafting a Best Practices Document Regarding Premium Increases**

Ms. Hatchette said the Working Group has previously discussed breaking into drafting groups to draft a best practices document regarding premium increases. Ms. Hatchette said several people have signed up for the various drafting groups; however, people can still be added to the drafting groups. She said there will be a lead regulator on each drafting group.

Ms. Hatchette said the drafting groups can collaborate with each other as necessary. She said it is important for policyholders to better understand premium increases. She said the Working Group had decided to split the drafting of the best practices document into five drafting groups.

a. **Drafting Group #1: Communication of a Premium Increase**

Ms. Hatchette said the task of the first drafting group would be to draft information regarding the communication of premium increase to policyholders. This section would cover the way insurers communicate with their policyholders regarding premium increases, whether it be social media, verbal communications, etc.

Ms. Hatchette said she hears consumers say they are unhappy because their insurer has not provided them with enough information regarding their premium increases. She said this drafting group will need to determine the best way for insurers to communicate, as well as how to communicate with policyholders. Ms. Hatchette said she believes this drafting group will need to focus on what industry is currently doing and what is working and what is not working.

b. **Drafting Group #2: Threshold for Notification of a Premium Increase**

Ms. Hatchette said the second drafting group was tasked with drafting information regarding setting a threshold for notification of premium increase (noting that each state would be able to set their own threshold).

Lisa Brown (American Property Casualty Insurance Association—APCIA) said she understood from the Working Group’s last meeting that the second drafting group would not be setting a threshold, per se, but to discuss and draft information regarding the methodology and logic behind the threshold.
Ms. Hatchette said this is the case, noting that the drafting group will not be recommending any particular threshold. She said she believes the drafting group would focus on considerations that states should think about, because each state may have its own laws and regulations in place already. Ms. Hatchette said this section should include information that would help state insurance regulators to make decisions regarding thresholds if they needed to do so.

Charles Angell (AL – Retired) asked if this would include making a threshold recommendation, as well as pros and cons to the recommendation, even though the Working Group would not be recommending a particular threshold.

Ms. Hatchette said this might be a difficult undertaking unless the drafting group reviewed the laws and regulations of each state. She also expressed concern about the time it would take to review all these laws and regulations.

c. Drafting Group #3: Communication Standards for a Premium Increase

Ms. Hatchette said the third drafting group was tasked with drafting communication standards for providing a premium increase, such as informing the policyholder of the current premium versus the renewal premium, and the explanation for the change, if any. She said the information would be what is actually being communicated, whether it be a dollar amount or a percentage.

Birny Birnbaum (Center for Economic Justice—CEJ) said he believes it will be more efficient to carry out the Working Group’s charge by combining drafting groups #1, #2 and #3. He said drafting group #3 would need to understand what they are trying to communicate before putting a mechanism into place. Mr. Birnbaum said it would also be important to know what threshold is before knowing what the drafting group wants to communicate. He said he believes all three of the items in drafting groups #1, #2 and #3 inform each other. Mr. Birnbaum said many Working Group members are members of all three drafting groups.

Mr. Bradner said he likes Mr. Birnbaum’s suggestion. He asked if drafting groups #1, #2 and #3 could be broken down into stages. Mr. Bradner said the first item to be addressed would be to determine the threshold. He said next the drafting group could then address the various communications channels. Mr. Bradner suggested the combined drafting group might first discuss the threshold, then discuss the communications standards, and, finally, discuss the ways to communicate the premium increases.

Mr. Bradner said the drafting of the threshold section should be able to be accomplished in a couple of meetings. He said then the drafting group would move on to discuss the format in which the information is going to be communicated to policyholders. Finally, the drafting group would look at the vehicles for communicating the information, as well as how various age groups might want to receive communication.

Ms. Hatchette, Mr. Allen and Ms. Wildman all said they believe that the drafting group responsible for determining the ways to communicate a premium increase to the policyholders could stand on its own. All agreed that the section for setting a threshold for notification of premium increase and communication standards for providing the premium increase could be combined.

The consensus of the Working Group was to combine drafting groups #1, #2 and #3 into one group. Mr. Bradner will lead this combined drafting group.

d. Drafting Group #4: Rate and Rule Filing Checklist

Ms. Hatchette said the fourth drafting group was tasked with coming up with a rate and rule filing checklist to be used by a state insurance department. She said Kansas has a particular checklist in place that they currently use. Ms. Droge said she would lead this drafting group.

e. Drafting Group #5: Consumer Education About Premium Increases

Ms. Hatchette said the final drafting group was tasked with providing consumer education about premium increases. She said this portion of the document would be the section that informs consumers in general regarding what they need to know about premium increases. Ms. Hatchette said this section would also inform consumers of things they could do to mitigate a premium increase.
Mr. Angell asked if this section would include education regarding premium capping. He said this is one of the more confusing aspects of explaining premium increases.

Ms. Hatchette said it is important to try to explain this concept. The Working Group agreed that this topic should be covered in the consumer education section.

Ms. Hatchette said it is important to think about how the consumer understands the premium increase documents they receive. Ms. Shortt will chair this drafting group.

Ms. Hatchette asked the drafting groups to meet within the next couple of weeks to set up organizational calls for each of the drafting groups. NAIC staff will find available dates for the drafting groups to meet and set up the meetings.

Having no further business, the Transparency and Readability of Consumer Information (C) Working Group adjourned.
The Transparency and Readability of Consumer Information (C) Working Group of the Property and Casualty Insurance (C) Committee met Feb. 4, 2021. The following Working Group members participated: Joy Hatchette, Chair (MD); Ken Allen (CA); Robert Rapp (IL); Carrie Couch and LeAnn Cox (MO); Chris Aufenthie (ND); Tricia Goldsmith (OR); and J'ne Byckovski (TX). Also participating were: Renee Campbell (MI); Tracy Klausmeier (UT); and Donna Stewart (WY).

1. **Discussed the Need for Consumer Disclosures Regarding Significant Premium Increases on P/C Insurance Products**

Ms. Hatchette said the purpose of the call is to decide on a work plan to draft a best practices document about consumer disclosures for significant premium increases on property/casualty (P/C) insurance products. She said the best practices document should address the content, the method of delivery, the threshold for disclosure, and the respective roles of state insurance regulators and insurers. The Working Group has held discussions over the past few months about ideas that it believes the best practices document should include. Ms. Hatchette said these ideas include ways to communicate a premium increase to policyholders and ideas regarding what thresholds will trigger the notification of premium increases to those policyholders. The Working Group needs to be sure that there is an understanding regarding a state requiring particular thresholds based on its own rules and regulations.

Ms. Hatchette said the Working Group additionally discussed communication standards for providing premium increases to policyholders. She said the Working Group discussed the items that need to be communicated to policyholders, as well as when this information should be provided to the policyholder. The Working Group has also discussed the type of explanation policyholders should receive. Ms. Hatchette said during the Working Group’s discussions, rate and rule filing checklists were also discussed. She said the Working Group believes these should also be included in the best practices document.

Ms. Hatchette said the Working Group also concluded that it would be a good idea to include some basic education for consumers regarding what constitutes a premium increase, as many people do not understand premium increases. This type of information would include a basis for understanding why a policyholder’s premium is increasing and the factors that go into a premium increase. These items provide some baseline information regarding a premium increase.

The Working Group decided that it would be most efficient to break into multiple drafting groups to begin drafting the document. Each drafting group will be assigned a section to draft. Once each section has been drafted, the Working Group will discuss the sections at the Working Group level.

The Working Group agreed to separate the best practices document into five drafting groups. These drafting groups include groups to discuss the following topics: 1) ways to communicate a premium increase to policyholders; 2) setting a threshold for the notification of premium increases, noting that each state would be able to set their own thresholds; 3) communication standards for providing premium increases, such as informing the policyholder of the current premium versus the renewal premium and the explanation for that change; 4) rate and rule filing checklists to be used by each state department of insurance (DOI); and 5) consumer education about premium increases.

Ms. Hatchette said examples for ways to communicate a premium increase to policyholders would include items such as: 1) whether communication increase to a policyholder should be a notice; 2) if so, when and how that notice should be sent; 3) whether the notice should be sent at the time of renewal or in advance of renewal; and 4) whether the notice should be sent electronically.

NAIC staff will send out a list of the various drafting groups to Working Group members, interested state insurance regulators, and interested parties. Once the list of volunteers is compiled, meetings among the drafting groups will begin.

Having no further business, the Transparency and Readability of Consumer Information (C) Working Group adjourned.
The Transparency and Readability of Consumer Information (C) Working Group of the Property and Casualty Insurance (C) Committee met Nov. 17, 2020. The following Working Group members participated: Joy Hatchette, Chair (MD); Willard Smith (AL); Ken Allen (CA); Tracy Garceau (CO); George Bradner (CT); Heather Droge and Brenda Johnson (KS); Tricia Goldsmith (OR); Vickie Trice (TN); and Marianne Baker, David Dolduc and Laura Machado (TX). Also participating were: Renee Campbell (MI); Chanell McDevitt (NJ); and Jana Jarrett (OH).

1. Discussed the Need for Consumer Disclosures Regarding Significant Premium Increases on P/C Insurance Products

Ms. Hatchette said the Working Group would discuss the “Rate/Ruling Checklist” that Kansas has in place. Ms. Droge said the “Rate/Ruling Checklist” is part of Kansas’ general instructions it requires insurers to complete with all of its rate and rule filings. She said if the insurer does not return a completed checklist, then Kansas will reject the filing.

Ms. Droge said the purpose of the checklist is to allow Kansas to capture the information it needs to complete the extraordinary memorandum it provides, as well as to help speed to market. She said the checklist allows Kansas to have everything it needs upfront to be more efficient.

Ms. Droge said the first item requested on the checklist reads: “All rate information must be completed on the rate/rule tab without capping.” She said sometimes insurers may not provide information regarding the maximum or minimum rate increase. This requires the state to go back to the insurer to ask for this information, which slows down the review or creates another objection that they feel is unnecessary.

Ms. Droge said the second item requested on the checklist reads: “All proposed rate/rule manual pages must be submitted under the rate/rule schedule tab for approval.” She said Kansas requires all the rate and rule manual pages to be submitted. Ms. Droge said Kansas asks for any changes being made to be submitted.

The third item requested on the checklist reads: “Complete rate/rule manual tab with all proposed changes must be submitted under supporting documents tab as this will be marked informational only. A complete manual should consist of all corresponding rules for your optional forms, all rules corresponding to your rating factors, all rating factors, territory definitions and factors, and all proposed changes to rules and rates.” She said this information is important to Kansas because it does a manual comparison to be sure it can capture changes from a previous rate file to the file it is currently reviewing. If this is not received, the filing is rejected.

The fourth item on the checklist reads: “Provide a histogram on an uncapped basis. (If the file contains more than one company, please provide a separate histogram for each company).” Ms. Droge said this allows Kansas to see how many policyholders are getting the maximum increase and how many policyholders are getting the minimum increase. This information helps Kansas to write its extraordinary memorandum, as well as to provide information regarding the percentage of policyholders affected by the maximum rate increases. She said this allows Kansas to go back to the insurer and ask if there is a cap in place.

The fifth item on the checklist reads: “Provide the characteristics of the insured(s) receiving the maximum rate increase. (If the filing contains more than one company, please provide a separate histogram for each company).” Ms. Droge said this is helpful to help the state understand what is going on with the particular policy so it can be explained to consumers if they contact the Department of Insurance (DOI).

The sixth item on the checklist reads: “Provide the average dollar change, the maximum dollar change and minimum dollar change on an uncapped basis. (If the filing contains more than one company, please provide a separate histogram for each company).” Ms. Droge said this is helpful to the DOI, as it may want to ask for a cap.

The seventh item on the checklist reads: “Please provide our department with a talking points sheet that will assist our consumer assistance division should we receive consumer complaints regarding the rate increase. This submission should provide detailed information that we can share with policyholders that will explain what is causing this rate increase.” Ms. Droge said the
insurer provides these talking points to the DOI using their own words, which helps the DOI to provide information to consumers if they receive a consumer complaint. The information received from the insurer is not altered in any way and is put into the memorandum the DOI creates.

The eighth item on the checklist reads: “Please provide us with the breakdown of the permissible loss ratio by coverage including: 1) Taxes, licenses and fees; 2) Total production expense; 3) Underwriting profit; 4) Any other fees that comprise the permissible loss ratio; and 5) Permissible loss ratio.” Ms. Droge said this information is included so the examiners have it in their memorandum to be sure that number is accurate when compared to the loss ratio to make sure the rate increase is justified. She said if the number is not matching up, they can go back to the company and ask for an explanation as to why the rate increase is not justified.

The ninth item on the checklist reads: “Provide all support and justification exhibits for rate change including how you derived your overall indication, all support for proposed factor changes, etc.” Ms. Droge said this information includes how the insurer derives its overall indication and the support for the proposed changes for its factors. She said Kansas has a statute that requires insurers to include this information in their file. Ms. Droge said prior to using this checklist, insurers did not provide much detail. She said the statute allows the filing to be rejected if this information is not provided.

The 10th item on the checklist reads: “Provide the percentage breakdown of the rate impact per line of coverage. (If the filing contains more than one company, please provide a separate histogram for each company.) (**Only required for personal auto rate filings.)” Ms. Droge said this allows the DOI to look at impacts and how bodily injury and uninsured motorist lines are affected.

Ms. Droge said the checklist has allowed the DOI to receive more information from the insurer upfront. She said this allows the DOI to be more efficient. Ms. Droge said the DOI does not have any problems with insurers completing the document.

Mr. Allen asked if the checklist was used in conjunction with any other documentation. He said California created an array of documentation, including an application form, two sets of exhibits, a rate template that follows their regulations and a very large document of instructions on how to complete each of the documents. Mr. Allen said the DOI’s documentation is complex and has many requirements. He said once the filings are in, the DOI has documentation it uses internally to do a check to make sure that the information in the rate template matches with the information submitted in the exhibits and that the information in the exhibits matches the information submitted in the application. Mr. Allen said they are doing a validation of sorts regarding what was submitted to try to catch errors. He said a lot of this validation is automated. Mr. Allen said the DOI does not really have a checklist or anything currently in place that requires insurers to identify rate increases given to policyholders. Ms. Droge said the Kansas DOI uses this information mostly for writing an extraordinary memorandum for its consumer assistance division to use to assist with rate filings for some of the top writers. She said this information is required by statute for the exhibits contained within the System for Electronic Rate and Form Filing (SERFF) filings. Ms. Droge said the checklist used by the DOI asks for information it was having to go back to ask insurers for on a regular basis. She said this checklist has been in place for approximately five years and is used for both personal and commercial lines.

Amy Bach (United Policyholders—UP) asked if there was also a standardized form that an insurance agency puts out to notify consumers of premium increases. Ms. Droge said there is not a standardized form in Kansas. Ms. Bach asked if insurers were required to show the DOI examples of consumer notifications for premium increases. Ms. Droge said this was not required in Kansas.

Ms. Hatchette said one of the Working Group’s 2020 charges was to discuss whether there is a need for consumer disclosures regarding significant premium increases on property/casualty (P/C) insurance products. She said the Working Group will be reporting to the Property and Casualty Insurance (C) Committee during the Fall National Meeting regarding the Working Group’s findings. Ms. Hatchette asked if it was the will of the group to create a best practices document that would provide states some options as to what they might want to do individually to handle communications regarding significant premium increases. She said states would be able to refer to the best practices document and select the option that is the best fit for their state.

Ms. Hatchette said the best practices document would include items such as: 1) ways to communicate a premium increase to policyholders; 2) setting a threshold for notification of premium increase (each state would be able to set their own threshold for notification of a premium increase); 3) communication standards for providing the premium increase, such as informing...
the policyholder of the current premium versus the renewal premium, and the explanation for the change in premium, if any;  
4) rate and rule filing checklists to be used by a state DOI; and 5) consumer education regarding premium increases.

Ms. Droge asked how the Working Group would identify all the consumers who had a premium increase. Mr. Bradner asked it if could be included as a checkbox item as an increase of greater than some amount to a group of consumers the insurer has identified. Ms. Droge said the Kansas DOI only asks for this information for the top writers in the state and asked how this would be done for all writers. Ms. Baker said she thinks the idea was that the insurers will distribute the notices to the policyholders. Ms. Hatchette said the best practices document could provide choices, so a state could distribute the notice if it has the resources and chooses to do so.

Mr. Allen said the Working Group previously discussed capping. He asked if there is a cap in place, would the notice include this information. Mr. Allen suggested adding information regarding capping in the recommendations. He said he will provide language to add to the recommendation to the Working Group.

Ms. Hatchette said the consumer education (CE) portion of the document would be a piece that would explain premium increases to the consumer, as receiving a notice they do not understand is not helpful. She said the Working Group would create language to educate the consumer regarding premium increases.

Ms. Garceau said it would be helpful to have the insurer that is sending the information regarding premium increases provide contact information so the consumer can call the insurer with questions about the premium increase, as well as possible ways to reduce their premium. She said this would help to encourage communication between the policyholder and their insurer. Ms. Garceau said she will send suggested language to add to the recommendations.

Birny Birnbaum (Center for Economic Justice—CEJ) said the recommendation is too complicated and prescriptive for what needs to be done. He said the charge before the Working Group is to discuss whether there is a need for consumer disclosures regarding significant premium increases on P/C insurance products. Mr. Birnbaum said the report needs to consist of two things: 1) yes, the Working Group has determined there is a need for such a disclosure; and 2) the Working Group would like to develop such a disclosure. He said part of that disclosure would consider the content, method of delivery and the threshold for the disclosure. Mr. Birnbaum said all of the items discussed thus far fall into one of those three categories. Steve Clark (Insurance Services Office—ISO) said a body of requirements regarding notification on renewals already exists in many states. He said some of these requirements are by statute, some are in regulations, and some are by bulletin. Mr. Clark said the existing requirements regarding thresholds already exist and are between 10% to 25%. He said the thresholds can be set differently by line of business. Mr. Clark asked if this Working Group would be looking to determine new thresholds. Ms. Hatchette said the purpose of this document would be to provide best practices for a state. She said states would have the ability to use all or none of the suggestions. However, if a state has existing statutory or regulatory guidelines for thresholds, states would either follow the thresholds in place or impose any changes they might feel necessary. Ms. Hatchette said this Working Group will not be making changes to thresholds already in place.

Having no further business, the Transparency and Readability of Consumer Information (C) Working Group adjourned.

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CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

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The Casualty Actuarial and Statistical (C) Task Force met March 9, 2021. The following Task Force members participated: Grace Arnold, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Rich Piazza and Nichole Torbla (LA); Lori K. Wing-Heier represented by Katrina Kelly and Michael Ricker (AK); Jim L. Ridling represented by Daniel Davis (AL); Evan G. Daniels represented by Vanessa Darrah and Tom Zuppan (AZ); Ricardo Lara represented by Anna Chou, Giovanni Muzzarelli, Mitra Sanandajifar and Lynne Wehmueller (CA); Michael Conway represented by Mitchell Bronson and Sydney Sloan (CO); Andrew N. Mais represented by Susan Andrews, Wanchin Chou and Qing He (CT); Karima M. Woods represented by David Christhilf, Monica Dyson and Monica Myers (DC); Dana Popish represented by Sandra Severinghaus; Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd and Heather Droge (KS); Kathleen A. Birrane represented by Robert Baron, Ron Coleman and Walter Dabrowski (MD); Eric A. Cioppa represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by Cynthia Amann, Preston Nilges and LeAnn Cox (MO); Troy Downing represented by Mari Kindberg and Ashley Perez (MT); Mike Causey represented by Arthur Schwartz (NC); Chris Nicolopoulos represented by Christian Citarella (NH); Marlene Caride represented by Mark McGill (NJ); Russell Toal represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by TK Keen (OR); Jessica K. Altman represented by Kevin Clark, James DiSanto and Michael McKenney (PA); Raymond G. Farmer represented by Michael Wise (SC); Doug Slape represented by Monica Avila, J’ne Byckovski, Brock Childs, Nicole Elliott, Miriam Fisk, Eric Hintikka and Bethany Sims (TX); Michael S. Pieciak represented by Rosemary Raszka (VT); Mike Kreidler represented by Eric Slavich (WA); and Jeff Rude represented by Donna Stewart (WY). Also participating was: Tomasz Serbinowski (UT).

1. **Adopted its Feb. 17, 2021; Feb. 9, 2021; Feb. 2, 2021; Dec. 30, 2020; and Nov. 10, 2020, Minutes**

Mr. Vigliaturo said the Task Force met Feb. 17, 2021; Feb. 9, 2021; Feb. 2, 2021; and Dec. 30, 2020. During these meetings, the Task Force adopted statistical reports presented by the Statistical Data (C) Working Group.

The Task Force also met Feb. 16, 2021, in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss rate filing issues.


Mr. Piazza made a motion, seconded by Mr. Botko, to adopt the Task Force’s Feb. 17, 2021 (Attachment One), Feb. 9, 2021 (Attachment Two), Feb. 2, 2021 (Attachment Three), Dec. 30, 2020 (Attachment Four), and Nov. 10, 2020 (see NAIC Proceedings – Fall 2020, Casualty Actuarial and Statistical (C) Task Force) minutes. The motion passed unanimously.

2. **Adopted the Report of the Statistical Data (C) Working Group**

Mr. McGill said all the statistical reports have been approved, posted on the website, and released to the public.

Mr. McGill made a motion, seconded by Mr. Chou, to adopt the report of the Statistical Data (C) Working Group. The motion passed unanimously.

3. **Discussed the CAS’s Recission of its SoPs**

Mr. Vigliaturo said the Casualty Actuarial Society’s (CAS’s) recission of its collection of Statements of Principles (SoPs) was discussed on the Task Force’s Feb. 9 call. Some members of the Task Force volunteered to draft a letter to the CAS Board of Directors. Mr. Citarella said he, Ms. Krylova, Mr. Schwartz and Mr. McKenney drafted a letter for the Task Force to consider adopting and sending to the CAS. Mr. Citarella briefly described the letter’s content.
Ken Williams (CAS) provided a comparison of the SoPs on Ratemaking and the Actuarial Standards of Practice (ASOPs) (Attachment Five).

Jessica Leong (CAS), president of the CAS, said the CAS is hearing a lot of feedback on the CAS Board’s recission of the SoPs. She said the CAS takes the concerns being expressed and the professionalism of members seriously. She said given feedback to date, the CAS opened a formal comment period until March 15. The CAS Board will consider the feedback.

J. Robert Hunter (Consumer Federation of America—CFA) said he and other consumer groups support the draft letter (Attachment Six). He said there should be a linkage between final rates and cost. He said if the CAS rejects reinstatement of the principles, then he would suggest that the state insurance regulators would need to address the loss of the principles. He also supplied comments on the CAS’s comparison of the SoPs on Ratemaking and the ASOPs (Attachment Seven).

Mr. Stolyarov asked whether recission of the SoPs means the document can no longer be cited or republished. He also asked if the CAS would be amenable to gifting the principles to the public domain. Ms. Leong said she would find out and respond at a later date. Mr. Stolyarov said knowledge, in general, is objective irrespective of whether a specific organization considers it to be true. He said having the knowledge formulated in some way to be accessible to practitioners and those seeking to learn about the discipline would be useful. He said he believes the SoPs were useful in communicating the key areas. He said the principles should remain somewhere, either at the CAS or documented in some other way.

Peter Kochenburger (University of Connecticut School of Law) supported the letter, and he said a missing word might be “transparency” because it helps non-actuaries understand what the rules are. Ralph Blanchard (Travelers) clarified that the principles are not rules. He said “excessive, inadequate and unfairly discriminatory” are defined by each state’s statutes. For example, he said some states only consider rates to be “inadequate” if the rates would cause the insurer to be insolvent.

Mr. Citarella made a motion, seconded by Mr. Botsko, to adopt the attached letter and send it to the CAS (Attachment Eight). The motion passed unanimously.

4. Received a Report on the NAIC Rate Model Reviews

Kris DeFrain (NAIC) said in April 2018, the Executive (EX) Committee agreed with the Big Data (EX) Working Group’s recommendation to direct NAIC management to “conduct research on the appropriate skills and potential number of resources for the organization to help NAIC members in coordinating their reviews of predictive models.” NAIC senior management conducted the research and recommended gradual build-up of expertise at the NAIC to aid state insurance regulators’ review of property/casualty (P/C) rate models.

In 2019 with existing actuarial, legal and information technology (IT) staff, the NAIC did three things: 1) drafted a contractual agreement called the Rate Review Support Services Agreement (Agreement) to be used so a state can gain access to the shared model database and can request a rate model technical review from the NAIC; 2) developed the initial NAIC rate model technical review process with a consulting actuary, and 3) created a shared model database for confidential regulatory communication.

As of today, there are 28 states contracted with the NAIC using the Agreement. Of those 28 states, there is diverse participation from small states without P/C actuaries on staff to large states with actuarial teams. Twenty of the states are members of the Task Force.

The Agreement is set so the NAIC will review a rate model at the request of a state when resources are available. The NAIC’s technical review is consistent with the Task Force’s white paper, and it includes information such as what documentation is included or missing in the filing, any actuarial or statistical errors, and any potentially questionable support.

Ms. DeFrain said the NAIC does not assume any regulatory authority, create objections to be sent to the company, recommend acceptance or rejection of the model or any specific rating variable, or do separate modeling to determine any correlation with unlawful characteristics or assess disparate impact. The process and the report are subject to improvement over time, and suggestions are welcome.

In August 2020, the NAIC hired Sam Kloese (NAIC) to work with the rate model review team to implement the project. In total as of today, we have reviewed 31 rate filings and objection responses for nine states. The volume of requests is increasing. At the beginning of February, the team was already booked into March for reviews. NAIC staff is currently analyzing the
potential workload for this year and evaluating the need for additional resources. NAIC staff will soon be sending information to commissioners about potential resource needs to meet the demands for assistance.

Mr. Piazza asked if there is a list of filings that have been reviewed. Ms. DeFrain said the reviews are uploaded to the shared model database. She said she could also provide a list if desired. Mr. Piazza and Mr. Vigliaturo agreed that periodic communication to the state insurance regulators would be helpful.

Mr. Serbinowski asked if the NAIC review team would do presentations to the state insurance regulators to highlight the issues. Ms. DeFrain said Mr. Kloese presents case studies in months when the Task Force does not have a Book Club. She said the periodic communication requested by Mr. Piazza could also include a high-level overview of each model. She added that states can sign the Agreement with the NAIC and be under no obligation to do anything or ask the NAIC to conduct any reviews. She said the Agreement provides access to the database and case studies.

Birny Birnbaum (Center for Economic Justice—CEJ) asked for a copy of the Agreement, the processes and procedures for the shared model database, and the processes and procedures for the NAIC rate model reviews. Ms. DeFrain said parties can ask the states for a copy of the signed Agreement through their request for documents. She said there are no manuals for processes and procedures because it is a fairly simple process. She said there are instructions for use of the database, but they cover how to use the functions in the NAIC and do not describe processes and procedures. She said she would be happy to answer any direct questions. Mr. Birnbaum said this is a black box at the NAIC. He said he wants to know: 1) what provisions are in the Agreement, such as what confidentiality is promised; 2) what is included in the rate model review other than what has been said on this call; and 3) who can access the shared model database and what use it can be put to. He said he has been asking for this information at the NAIC for more than a year, and he believes this information should be public. He said he does not need content of the reviews. He asked if the NAIC’s report is available to the filers. Ms. DeFrain said this is a state decision. She said the NAIC does not provide actuarial opinions or step into the state insurance regulators’ role. He asked if the state is limited in its use of the review. Ms. DeFrain said she does not recall the Agreement restricting the use by the state insurance regulator.

Mr. Blanchard asked how long the reviews take. Ms. DeFrain said the reviews can take up to two weeks.

Robert Curry (Insurance Services Office—ISO) asked whether the filer would be notified that the NAIC is reviewing the model. He said the companies are notified when a consultant is involved. Ms. DeFrain said there is no notification process that is required. The state can inform you that they have requested an NAIC review. The state can list the NAIC as a reviewer if they choose. Ms. DeFrain said consultants provide opinions and write objections, putting themselves in the place of state insurance regulators. She said the NAIC does not do this.

5. **Heard Reports from Professional Actuarial Associations**

Ms. Cavanaugh said the Committee on Property and Liability Financial Reporting (COPLFR) produced its annual law manual and practice note on annual statement reserves and updated its COVID-19 frequently asked questions (FAQ). The Academy’s P/C Risk-Based Capital Committee produced a report on updated underwriting factors. The Academy’s Cyber Risk Task Force in cooperation with the Academy’s research team published individual states’ reporting requirements for cyber breaches. A paper is expected on COVID-19’s impact on auto ratemaking and a consumer-oriented paper to describe basic insurance concepts and rating for auto insurance. The Academy’s Casualty Practice Council formed a racial equity task force to address P/C race and insurance as it relates to public policy. Additional topics being monitored include the Pandemic Risk Insurance Act, flood insurance, the Terrorism Risk Insurance Program, and presumptive benefits for COVID-19. The Academy will assist with the NAIC Insurance Summit.

Mr. Blanchard provided the CAS’s research report (Attachment Nine). Dale Hall (Society of Actuaries—SOA) provided the SOA’s research report (Attachment Ten).

6. **Discussed Other Matters**

Mr. Vigliaturo said the Task Force’s white paper, *Regulatory Review of Rate Models*, will be considered for adoption by the Executive (EX) Committee and Plenary at the Spring National Meeting.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
The Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded Feb. 17, 2021. The following Task Force members participated: Grace Arnold, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Rich Piazza (LA); Lori K. Wing-Heier represented by Michael Ricker (AK); Jim L. Ridling represented by Daniel Davis (AL); Evan G. Daniels represented by Tom Zuppan (AZ); Ricardo Lara represented by Lynne Wehmueller (CA); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhilf and Angela King (DC); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen represented by Travis Grassel (IA); Dana Popish Severinghaus represented by Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd (KS); Eric A. Cioppa represented by Sandra Darby (ME); Chlora Lindley-Myers represented by Cynthia Amann (MO); Troy Downing represented by Mari Kindberg (MT); Marlene Caride represented by Carl Sornson (NJ); Russell Toal (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by David Dahl (OR); Raymond G. Farmer represented by Will Davis (SC); Doug Slape represented by J’ne Byckovski (TX); Michael S. Pieciak represented by Rosemary Raszka (VT); Mike Kreidler represented by Eric Slavich (WA); James A. Dodrill represented by Juanita Wimmer (WV); Jeff Rude represented by Donna Stewart (WY).

1. **Adopted the Auto Insurance Database Report**

The Task Force conducted an e-vote to consider adoption of the *Auto Insurance Database Report*. The motion passed unanimously.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
The Casualty Actuarial and Statistical (C) Task Force met Feb. 9, 2021. The following Task Force members participated: Grace Arnold, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Rich Piazza, Larry Steiners and Nichole Torblaa (LA); Lori K. Wing-Heier represented by Katrina Kelly and Michael Ricker (AK); Jim L. Ridding represented by Daniel Davis (AL); Evan G. Daniels represented by Vanessa Darrah and Tom Zuppan (AZ); Ricardo Lara represented by Ken Allen, Mitra Sanandajifar and Lynne Wehmueller (CA); Michael Conway represented by Mitchell Bronson and Eric Unger (CO); Andrew N. Mais represented by Susan Andrews and Wanchin Chou (CT); Karima M. Woods represented by David Christhilf and Monica Myers (DC); David Altmaier represented by Sandra Starnes (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen represented by Travis Grassel (IA); Dana Popish Sevemingesen represented by Reid Mc Clintock and Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd and Heather Droge (KS); Kathleen A. Birrane represented by Ron Coleman and Walter Dabrowski (MD); Eric A. Cioppa represented by Sandra Darby (ME); Chlora Lindley-Myers represented by Cynthia Amann and LeAnn Cox (MO); Troy Downing represented by Mari Kindberg and Ashley Perez (MT); Mike Causey represented by Kevin Conley and Arthur Schwartz (NC); Chris Nicolopoulos represented by Christian Citarella (NH); Marlene Caride represented by Mark McGill and Carl Sornson (NJ); Russell Toal represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarow (NV); Judith L. French represented by Benjamin Beckman and Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by David Dahl (OR); Jessica K. Altman represented by Kevin Clark, James DiSanto, and Michael Mc Kenney (PA); Raymond G. Farmer represented by Will Davis and Michael Wise (SC); Doug Slape represented by Monica Avila, J’ne Byckovski, Brock Childs, Nicole Elliott, Eric Hintikka, Jason Lester, Brian Ryder and Bethany Sims (TX); Michael S. Pietick represented by Rosemary Raszka (VT); Mike Kreidler represented by Dan Fornar (WA); James A. Dodrill represented by Tonya Gillespie and Juanita Wimmer (WV); Jeff Rude and Donna Stewart (WY). Also participating was: Gordon Hay (NE).

1. Adopted the Reports of the Actuarial Opinion (C) Working Group and the Statistical Data (C) Working Group

Mr. Vigliaturo announced the appointments of Ms. Krylova as chair and Miriam Fisk (TX) as vice chair of the Actuarial Opinion (C) Working Group, as well as Carl Sornson as chair and Mr. Chou as vice chair of the Statistical Data (C) Working Group.

Ms. Krylova said the Actuarial Opinion (C) Working Group has not met in 2021.

Mr. McGill said the Report on Profitability by Line by State (Profitability Report) was released publicly on Jan. 12. The Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report (Homeowners Report) was released publicly on Jan. 13. The Competition Report was posted on the NAIC website on Feb. 2. The Auto Insurance Database Report (Auto Report) will be considered for adoption via e-vote soon.

Mr. Piazza made a motion, seconded by Mr. Botsko, to adopt the reports of the Actuarial Opinion (C) Working Group and the Statistical Data (C) Working Group. The motion passed unanimously.

2. Discussed Project #2019-49: Retroactive Reinsurance Exception

Mr. Vigliaturo said the Statutory Accounting Principles (E) Working Group referred Project #2019-49: Retroactive Reinsurance Exception to the Task Force in January 2020. The project was initialized after receipt of a letter from the American Academy of Actuaries’ (Academy) Committee on Property and Liability Financial Reporting (COPLFR). Mr. Vigliaturo said Mr. Hay, Ms. Fisk and Mr. Botsko have been working on this difficult project.

Mr. Hay said Statement of Statutory Accounting Principles (SSAP) No. 62R — Property and Casualty Reinsurance does not deal with every possible reinsurance arrangement, but rather only the more commonly employed methods. Prospective exceptions to prescribed retroactive accounting appear in paragraphs 36 and 39. He said these exceptions emerged individually from historical circumstances, so unanticipated future circumstances are possible. For the identified exceptions, the default assumption is that prescribed prospective accounting, including Schedule P Instructions, will apply with no modification. In a few circumstances, the SSAPs (including SSAP No. 6R) require restatement of historical calendar years’ earned premium and/or losses on...
Schedule P. He said he, Ms. Fisk and Mr. Botsko need to reconcile the default assumption versus prescribed restatements, with examples of insurers and reinsurers’ actual Schedule P presentation, including the two examples in the COPLFR letter that gave rise to Project #2019-49. He said in some important examples, state interpretations in real time, rather than company decisions, created precedents for divergent Schedule P presentation in subsequent years. He said he still hopes to recommend appropriate Schedule P presentation guidance for each exception identified in SSAP No. 62R paragraphs 36 and 39. Mr. Hay said he, Ms. Fisk and Mr. Botsko are working on a recommendation to improve prospective reinsurance accounting prescriptions in SSAP No. 62R paragraphs 30–32 and paragraphs 49–54 (cedants’ accounting and credit taken) or paragraphs 42–48 (reinsurers’ accounting).

3. **Discussed CAS Recission of Statements of Principles**

Mr. Vigliaturo said the Casualty Actuarial Society (CAS) notified the Task Force that it rescinded its collection of Statements of Principles, including the ratemaking principles that many states use when reviewing rate filings. He said after the CAS presentation, he would like to hear from state insurance regulators and interested parties about the impact on state regulation and whether state insurance regulators want to take any actions such as creating NAIC principles on ratemaking or leave such decisions to individual states.

Ken Williams (CAS) said the impact on states was intended to be minimal. He said all the statements of principles (ratemaking, reserving and evaluation) were written in the late 1980s before Actuarial Standards of Practice (ASOPs) were developed and were intended to be a foundation for the development of standards. With more than 50 ASOPs developed today, he said the ASOPs are now robust, enforceable and somewhat prescriptive. He said the view is that the principles have served their purpose to be a foundation for ASOPs. He added the principles often parallel the ASOPs, with any differences sometimes leading to confusion.

Mr. Williams said actuaries are held to professional standards within the U.S. and are required to follow the Code of Conduct, ASOPs, Qualification Standards and state regulations. Mr. Williams said the CAS is now a worldwide organization. He said every state has “not excessive, not inadequate and not unfairly discriminatory” language in their regulatory statutes. He said the CAS notified the three states with direct reference to the statement of principles in laws or regulations.

State insurance regulators expressed multiple views: 1) the Task Force was dissatisfied that the CAS did not request comment from its membership before rescinding, and there might have been some concerns; 2) states may use the principles for other purposes, including a data call which cited the principles; 3) lawmakers would look to the CAS as experts on ratemaking and may interpret rescission of the principles as a need to rewrite laws on rates; 4) state insurance regulators make the principles enforceable by referring to the principles in certain situations; and 5) the principles on ratemaking seemed to be more specific than ASOPs, and some concepts do not exist in the ASOPs. The CAS was asked to send the Task Force a comparison of the principles with the ASOPs to be able to evaluate the redundancy. Mr. Williams said he would prepare a comparison for distribution.

J. Robert Hunter (Consumer Federation of America—CFA) described his document sent to the Task Force for the meeting (Attachment Two-A). He said the only public actuarial requirement that final rates be related to risk was rescinded. The Actuarial Standards Board (ASB) had tried to write an ASOP for the final rate and had to back off because of unfair discrimination. In the mid-2010s, there was a five-year debate on these issues, and then suddenly the CAS Board rescinded the principles. Initially, the principles were not going to be rescinded until the ASOPs covered the principles. There is now no final rate principle, so actuaries could use price optimization. Many documents refer to the statements of principles. Mr. Hunter suggested the Task Force urge the CAS to reverse its rescission at least long enough to seek input. If the CAS does not reinstate, then he suggested the NAIC create a bulletin for the states to delete references of sound actuarial principles in rate regulation and laws. He said another option would be for the Task Force to propose the four principles be codified into laws to define actuarial soundness of rates.

Birny Birnbaum (Center for Economic Justice—CEJ) said the CAS could un-rescind the principles without notice and with immediate effect. He said the flawed process suggests the state insurance regulators have some urgency on this matter. Actuaries in rate hearings often quote the statements of principles.

Ralph Blanchard (Travelers) said the CAS generally stays out of the public policy arena. He said Article 9 of the CAS constitution says any public policy action requires a three-quarters vote of the Board. Based on his experience at the CAS, he said he expected there was a fair amount of analysis before the Board acted.
Ms. Amann said that given the reliance on the principles, the Task Force could develop its own principles. She said the document would then be controlled by state insurance regulators. She said if comfortable with the principles and the CAS does not reinstate the principles, then state insurance regulators can adopt the principles themselves. Mr. Birnbaum said that has merit, but many states refer to “sound actuarial principles” of practice. He said there needs to be a solution in the short term. Mr. Stolyarov said “sound actuarial principles” do not rely on a document from an organization. He said the principles are concepts, and state insurance regulators can quote sources that have no power over the rates. He said there is no real short-term impact. He said similar content developed by the state insurance regulators could be effective guidance. Mr. McKenney and Mr. Citarella said principles developed at the NAIC are non-binding. Mr. Citarella said he quotes the principles when working with legislators, so rescission makes that process more difficult.

Some members of the Task Force will draft a letter to the CAS for the Task Force’s future consideration.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
COMMENTS OF J. ROBERT HUNTER, FCAS, MAAA, 
DIRECTOR OF INSURANCE FOR CFA 
BEFORE THE CASUALTY ACTUARIAL AND STATISTICAL TASK FORCE 
OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS 
FEBRUARY 9, 2021 
AGENDA ITEM 3: DISCUSS CAS RESCISSION OF STATEMENT OF PRINCIPLES 
AND IMPACT ON STATES 

EXECUTIVE SUMMARY 

The fundamental basis of insurance ratemaking is that rates must be related to risk. For 
decades, that concept has been made explicit for actuaries in the Casualty Actuarial Society's 
Statement of Principles Regarding Property and Casualty Insurance Ratemaking, which sets out 
the following four related Principles:

Principle 1: A rate is an estimate of the expected value of future costs. Ratemaking 
should provide for all costs so that the insurance system is financially sound.

Principle 2: A rate provides for all costs associated with the transfer of risk. 
Ratemaking should provide for the costs of an individual risk transfer so that equity 
among insureds is maintained. When the experience of an individual risk does not 
provide a credible basis for estimating these costs, it is appropriate to consider the 
aggregate experience of similar risks. A rate estimated from such experience is an 
estimate of the costs of the risk transfer for each individual in the class.

Principle 3: A rate provides for the costs associated with an individual risk transfer. 
Ratemaking produces cost estimates that are actuarially sound if the estimation is based 
on Principles 1, 2, and 3. Such rates comply with four criteria commonly used by 
actuaries: reasonable, not excessive, not inadequate, and not unfairly discriminatory.

Principle 4: A rate is reasonable and not excessive, inadequate, or unfairly 
discriminatory if it is an actuarially sound estimate of the expected value of all future 
costs associated with an individual risk transfer.

The CAS Board of Directors rescinded these Principles on December 22, 2020. To my 
knowledge, they did this with no public warning or request for input, not even from their 
Members. It was entirely foreseeable that such a move would be controversial based on the 
effort to alter the language of the SOP a few years ago, which makes the surreptitious nature of
this action all the more concerning. Many at NAIC will recall CAS withdrawing its controversial rewrite of the SOP in 2016 and, the next year, ASB failing to produce a comprehensive ASOP for Ratemaking, citing the controversy over issues like price optimization and unfair discrimination.

CAS claimed the rescissions were justified because of overlap between the SOPs and 50+ ASOPs. They did not point out that only five of the 50+ ASOPs relate to important specific aspects of P/C ratemaking, but no ASOP governs the final, selected rate.

So, today there is no actuarial standard that covers the final rate. After December 22, 2020, an actuary could file a rate with the state, with five aspects of the rate fully complying with ASOPs and, at the end, pick any rate to file the actuary wanted, including rates adjusted by a price optimization algorithm or just picked out of the air. The actuary could properly confirm to the regulator that this rate “meets all actuarial standards.”

The SOP on ratemaking has been relied upon by regulators and state legislators who often include language referencing sound actuarial principles or practices, sometimes mentioning the now defunct CAS SOP by name. The rescission leaves a major gap . . . and opens the door to the discredited efforts to de-link rates from expected costs.

We ask the CASTF to urge the CAS to reverse their rescission of the ratemaking principles. Failing that, we ask that the CASTF recommend that the NAIC issue a bulletin to the states to act to delete any references to sound actuarial principles in rate regulation laws and regulations. Alternatively, CASTF could give consideration to proposing that states codify the Principles into laws defining actuarial soundness.

BACKGROUND OF 3 MAJOR ACTIONS ON RATEMAKING STANDARDS BY CAS AND ASB

1. In 2016, CAS stopped work on a revision to their Ratemaking Principles.

Here is their explanation of that withdrawal:

**UPDATE ON THE PROPOSED REVISIONS TO THE CAS STATEMENT OF PRINCIPLES REGARDING PROPERTY AND CASUALTY INSURANCE RATEMAKING**

08/25/2016 —

In early 2015, the CAS released for comment a Discussion Draft of proposed revisions to the Statement of Principles Regarding Property and Casualty Insurance Ratemaking (Statement). The Statement was released concurrently with a draft Actuarial Standard of Practice (ASOP) on Property/Casualty Ratemaking from the *Actuarial Standards Board* (ASB).

Since the release of the Discussion Draft in 2015, the work on the Statement by the CAS Statements of Principles Task Force has been suspended while the ASB continues to
develop its ASOP. While it was initially thought that the two documents should be
developed in tandem, it was ultimately concluded that it was better to limit the number
of "moving parts" in the development process. Therefore, the CAS will wait until the ASB
has completed the development of its ASOP, and then assess, in light of the ASOP, how
to amend the Statement to avoid duplicative, conflicting or confusing guidance for
actuaries.

The ASB issued a second exposure draft of its proposed ASOP on Property/Casualty
Ratemaking in February 2016 with comments due by April 30, 2016. The proposed new
ASOP addresses items in the Considerations section of the Statement, as well as
ratemaking items not currently addressed in existing ASOPs.”

In fact, the reason for the withdrawal by CAS was the significant opposition to the CAS draft,
including from Commissioners, because it eliminated the requirement that rates be cost-based.
CAS did promise to “wait until the ASB has completed the development of its ASOP” on
ratemaking. However, a complete ratemaking ASOP has never been developed.

2. In 2017, the ASB withdrew its proposed ASOP on ratemaking.

The same opposition to the ASB draft ASOP on Property/Casualty Ratemaking (i.e., that it
resulted in allowing rates that were not cost-based) resulted in the ASB draft also being
withdrawn.

That draft was replaced by ASOP 53, Estimating Future Costs for Prospective Property/Casualty
Risk Transfer and Risk Retention (not in any way related to the entire final rate). When
announcing the new ASOP, the ASB made clear that key questions that led CAS to end its
revision efforts the prior year pending resolution of the issues by ASB remained unresolved.
ASB stated this clearly, as follows:

In crafting this ASOP and responding to comments from its initial exposures, the ASB
quickly realized that there are significant differences of opinion within the profession
regarding certain aspects of ratemaking, including pricing, price optimization
methodologies, and rate filing requirements, that would need to be reconciled before a
comprehensive standard of practice on ratemaking could be developed. Therefore, to
create a standard of practice for the core aspects of ratemaking that could be issued in a
reasonable amount of time, the ASB has chosen to develop this ASOP to pertain solely
to the development or review of future cost estimates for prospective property/casualty
risk transfer and risk retention. It should be noted, however, that upon completion of
this proposed ASOP, the ASB will give consideration to the development of a standard of
practice on rate filings in an attempt to address the various issues within rate regulatory
discussions today (for example, price optimization, unfair discrimination, and the
Principles contained in the current CAS Statement of Principles).”
This disclaimer, provided in the ASOP transmittal memorandum, makes clear that the ASB has no standard covering the final rate and an ASOP to cover the final rate remains to be developed.

3. IN 2020, The CAS rescinds the Statement of Principles on P/C Ratemaking

Even though CAS promised not to act to amend the Statement of Principles Regarding Property/Casualty Ratemaking, the CAS suddenly rescinded the Statement, with this explanation:

The original Statement of Principles were drafted before any Actuarial Standards of Practice were developed or promulgated by the Actuarial Standards Board. The adoption of the 50+ Actuarial Standards of Practice in the United States over the past 30 years, as well as the adoption of standards in many other jurisdictions, has resulted in considerable overlap between certain standards and the Statement of Principles. Therefore, the CAS Board has determined that the Statements were no longer necessary and that rescinding them will eliminate any confusion that may have existed between actuarial principles and actuarial standards.

The CAS argument supporting the rescission – that “50+ Actuarial Standards of Practice...has resulted in considerable overlap between certain standards and the Statement of Principles” – appears to be disingenuous. Of the 56 ASOPs adopted by the Actuarial Standards Board, only 11 (12 did exist but one has been withdrawn) apply to P/C insurance at all. Of these, only five directly relate to P/C ratemaking (#13 Trending, #29 Expense Provisions, #30 Profit and Contingency, #39 Catastrophes, and # 53 Future Costs for Prospective P/C Risk Transfer and Risk Retention). These are important discrete elements of ratemaking, none of which, as the ASB itself says, contain a “standard of practice on rate filings.” The only such standard, until now, was the Statement of Principles Regarding Property and Casualty Ratemaking of the CAS. But since December 22, 2020 that’s gone.

As they moved toward rescission, the CAS acted with no public comment as far as I am aware; the Members of CAS were not even asked to comment. This is a strange process when you consider the fact that, when considering changes to the language of the Principles heretofore, CAS asked for comments and received many responses. CAS leadership should have known from their own experience in 2014-2016, having to withdraw their proposed changes to the Principles, that this would be a controversial act. Certainly the depth of interest and concern among actuaries, regulators and others about the SOP was in evidence to CAS leadership again when the ASB unsuccessfully attempted to develop the ASOP on final rates. The ASB did not hide the need for ongoing stakeholder engagement in this area when it noted “significant differences of opinion within the profession regarding certain aspects of ratemaking, including pricing, price optimization methodologies, and rate filing requirements, that would need to be reconciled before a comprehensive standard of practice on ratemaking could be developed.” It is shocking that the CAS acted in such a stealthy way to pull off this rescission.
DISCUSSION OF THE PROBLEM FACING CASTF TODAY

The problem before the regulators and for consumers is obvious. No ASOP exists that applies to the final rate to be charged to policyholders. The ASOPs that exist only relate to specific aspects of ratemaking, not the final rate. CAS, supposedly waiting for the ASB to act on a ratemaking ASOP, went ahead and acted to eliminate the Statement of Principles Regarding P/C Ratemaking before the ASB even has a draft ASOP for the final rate. This means that the issues such as price optimization and unfair discrimination, mentioned as serious controversies by ASB when it did not propose an ASOP for the final rate, are unresolved.

So, since December 22, 2020 we have no actuarial guidance in place on the final rate to be charged. In other words, the actuary could make rates fully compliant with every ASOP relating to specific elements of the filing and, at the end, select any final rate to file, whether to grab market share or implement a price optimization algorithm, and still be able to declare the regulator that this rate “meets all existing actuarial standards”.

There is another implication of this rescission. The linkage between the actuarial standards and statutory requirements is broken. The statutes require risk-based rates, often cited as “actuarially sound” rates, while the actuarial standards no longer require that final rates are risk-based. Talk about confusion. This is a very serious problem that CASTF must face.

Of course, those who want to use price optimization and other models such as Consumer Lifetime Value to move the price away from the cost-based rate now have no actuarial standard barrier to overcome.

Fortunately, state rating laws still require rates not to be excessive, inadequate or unfairly discriminatory. The standard has always tied back to cost-based pricing. Regulators will still have the capacity to protect consumers since rates will remain unfairly discriminatory if two consumers of identical risk are charged different prices simply because of non-risk differences such as shopping habit or potential future purchases of other products. But the murkiness created by the removal of actuarial standards for filed rates will embolden insurers and weaken the hand of regulators to protect consumers and secure a fair marketplace. I know, from careful review of many rate filings in recent years, that insurers often do not disclose clearly to the regulators what is going on inside a filing (e.g., price optimization) and it is very complex indeed to dig such items out.

PROPOSED RESPONSE BY CASTF

So, what should CASTF do?

The hole in actuarial standards is a thumb in the eye of CASTF, which specifically opposed CAS’s prior attempt to change the language in the Ratemaking principles to allow Price Optimization. Now CAS has accomplished this by fiat, taking sudden action with no comments even from its own members.
State insurance laws mention the CAS Statement of Principles on P/C Ratemaking. For example, Oklahoma defines acceptable actuarial standards as “the standards adopted by the Casualty Actuarial Society Statement of Principles Regarding Property and Casualty Ratemaking or the Standards of Practice adopted by the Actuarial Standards Board.” But now Oklahoma has a definition of acceptable actuarial standards that relies on a non-existent standard. Worse, if ASOPs alone define “acceptable actuarial standards,” there is no standard at all that applies to the final rate. Indeed, the definition with no CAS Principle in place, opens the door to the discredited efforts to de-link rates from expected costs.

CFA calls upon CASTF to take the following actions:

First, CASTF should urge the CAS to reinstate the Principles. If CAS refuses, CASTF should propose that the states delete any reference to sound or acceptable actuarial standards in statute since there’s no longer alignment between the actuarial standards and the statutory standards.

Second, CASTF should consider proposing a Model Law codifying the four Principles of the rescinded SOP into a definition of sound or acceptable actuarial standards for state rating laws. Although the CAS has, in my view, dishonored itself by the action it took on December 22, 2020, CASTF can ensure that that action will have no adverse effect on insurance regulation or the insurance marketplace by codifying the Principles the CAS has rescinded.
The Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded Feb. 2, 2021. The following Task Force members participated: James J. Donelon, Vice Chair, represented by Rich Piazza (LA); Lori K. Wing-Heier represented by Michael Ricker (AK); Jim L. Ridling represented by Daniel Davis (AL); Evan G. Daniels represented by Tom Zuppan (AZ); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhilf (DC); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen represented by Travis Grassel (IA); Dana Popish Severinghaus represented by Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd (KS); Eric A. Cioppa represented by Sandra Darby (ME); Chlora Lindley-Myers represented by Cynthia Amann (MO); Troy Downing represented by Mari Kindberg (MT); Mike Causey represented by Kevin Conley (NC); Chris Nicolopoulos represented by Christian Citarella (NH); Marlene Caride represented by Carl Sornson (NJ); Russell Toal represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Tynesia Dorsey represented by Tom Botsko (OH); Andrew R. Stolfi represented by David Dahl (OR); Jessica K. Altman represented by Michael McKenney (PA); Raymond G. Farmer represented by Will Davis (SC); Doug Slape represented by J’ne Byckovski (TX); Michael S. Pieciak represented by Rosemary Raszka (VT); Mike Kreidler represented by Eric Slavich (WA); James A. Dodrill represented by Juanita Wimmer (WV); and Jeff Rude (WY).

1. **Adopted the Competition Database Report**

The Task Force conducted an e-vote to consider adoption of the *Competition Database Report*. All voted in favor of adoption. The motion passed.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
The Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded Dec. 30, 2020. The following Task Force members participated: Grace Arnold, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Rich Piazza (LA); Lori K. Wing-Heier represented by Michael Ricker (AK); Jim L. Ridling represented by Daniel Davis (AL); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhilf (DC); Doug Ommen represented by Travis Grassel (IA); Shannon Whalen represented by Anthony Bredel (IL); Vicki Schmidt represented by Nicole Boyd (KS); Eric A. Cioppa represented by Sandra Darby (ME); Chlora Lindley-Myers and Cynthia Amann (MO); Chris Nicolopoulos represented by Christian Citarella (NH); Marlene Caride represented by Carl Somson (NJ); Russell Toal represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Tynesia Dorsey represented by Laura Miller (OH); Glen Mulready represented by Andrew Shallhorn (OK); Andrew R. Stolfi represented by David Dahl (OR); Jessica K. Altman represented by Michael McKenney (PA); Raymond G. Farmer represented by Will Davis (SC); Doug Slape represented by J’ne Byckovski (TX); Michael S. Pieciak represented by Rosemary Raszka (VT); and Mike Kreidler represented by Eric Slavich (WA).

1. **Adopted the Profitability Report and the Homeowners Report**

The Task Force conducted an e-vote to consider adoption of the *Report on Profitability by Line by State* (Profitability Report) and the *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report* (Homeowners Report). All voted in favor of adoption. The motion passed.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
Comparison of ASOP 53 and CAS Principles of Ratemaking

Considerations and definitions discussed in both documents

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Considerations covered in other ASOP’s

| Homogeneity                                       | ASOP 12 Risk Classification |
|                                                  | 2.5 Homogeneity              |
|                                                  | 3.3.2 Actuarial Considerations|
| Actuarial Judgment                               | ASOP 1 Introduction to ASOPS |
|                                                  | 2.9 Professional Judgement    |
|                                                  | 3.1.3, 3.1.4                 |

Other considerations in ASOP 53 not mentioned in Statement of Principles

- Methods, Models and Assumptions
- Considerations for New Coverages
- Infrequent Events other than Catastrophes
- Additional Funding Sources (refers to assessments)

Items in Statement of Principles considerations not specifically covered by ASOP 53 or related ASOPs

- Loss Development
- Individual Risk Rating
March 8, 2021

CFA SUPPORTS THE CASTF DRAFT LETTER CALLING UPON CAS TO REVERSE THE RESCISSION OF THE PRINCIPLES OF P&C RATEMAKING

To CASTF Members:

As your draft letter makes clear, the heart and soul of the now rescinded CAS SOP are in the Principles section where the Four Principles of Ratemaking are delineated. Both as a matter of process and substance, the decision by CAS to unceremoniously and without warning drop the ratemaking principles that have served as the foundation of regulatory practice for 30 years is unacceptable. The draft letter CASTF has presented speaks clearly to the importance of these Principles as key actuarial guidance and as a clear and concise tool for explaining the standards and parameters of our profession.

CASTF has a vital role to play to assure that these standards remain in place in one form or another. Without them, the movement away from cost-based rates, in violation of state rating laws, will accelerate. This would open the door to abuse, particularly of the poor and people of color. Your draft letter is a great step in the direction of maintaining cost-based prices. Should CAS refuse to reinstate the SOP, CASTF must stand ready to act to make the four Principles a regulatory standard for actuaries to continue to rely upon.

Sincerely,

J. Robert Hunter, FCAS, MAAA
Director of Insurance
TWO GLARING OMISSIONS IN DOCUMENT ATTACHED TO CASTF MATERIALS REGARDING ITEM 3 OF THE UPCOMING MARCH 9, 2021 CALL

The document, “Comparison of ASOP 53 and CAS Principles of Ratemaking” ignores the most important part of the rescinded SOP and, as the subtitle indicates, only looks at the less important “considerations and definitions” sections of the rescinded SOP.1

The comparison in this document could be confused to some readers as showing that ASOP 53 and other ASOPs are almost be a complete substitute for CAS Statement of Principles Regarding Property and Casualty Insurance Ratemaking. That is simply not true. The document only addresses lesser aspects of the CAS SOP on Ratemaking and does not address two central purposes of the rescinded CAS SOP: the Principles themselves and the linkage of final rates to cost-based indications.

1. The Document Ignores the Central Purpose of the Rescinded SOP on Ratemaking:

The heart and soul of the now rescinded CAS SOP is in the Principles section where four Principles of Ratemaking are delineated. They are:

_Ratemaking is prospective because the property and casualty insurance rate must be developed prior to the transfer of risk._

_Principle 1: A rate is an estimate of the expected value of future costs. Ratemaking should provide for all costs so that the insurance system is financially sound._

_Principle 2: A rate provides for all costs associated with the transfer of risk._

_Ratemaking should provide for the costs of an individual risk transfer so that equity among insureds is maintained. When the experience of an individual risk does not provide a credible basis for estimating these costs, it is appropriate to consider the aggregate experience of similar risks. A rate estimated from such experience is an estimate of the costs of the risk transfer for each individual in the class._

_Principle 3: A rate provides for the costs associated with an individual risk transfer._

_Ratemaking produces cost estimates that are actuarially sound if the estimation is based on Principles 1, 2, and 3. Such rates comply with four criteria commonly used by actuaries: reasonable, not excessive, not inadequate, and not unfairly discriminatory._

1 That ASOP 53 covers the “considerations” section of the rescinded CAS SOP on Ratemaking is no surprise. As ASB said, in transmitting ASOP 53 to actuaries, “It should be noted that this ASOP incorporates all of the Considerations contained in the CAS Statement of Principles and addresses issues related to the estimation of costs for risk transfer and risk retention not currently addressed in existing ASOPs. This ASOP also references other existing ASOPs that include relevant issues related to the estimation of future costs for prospective risk transfer and risk retention.”
Principle 4: A rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer.

There is nothing in ASOP 53 or in any ASOP that addresses these key Principles, even remotely. (Please note that the rescinded Principle 4 contains language similar or identical to that which appears in the insurance rating laws of almost every state)

2. The Document Ignores the Fact that Final Rates Charged to Consumers are no Longer Covered by any Actuarial Standard or Principles:

Where the rubber hits the road when it comes to ratemaking are the final rates charged to consumers of insurance. ASOP 53 and all other ASOPs currently in place have no impact on final rates charged to policyholders. As ASB said in December 2017, in transmitting ASOP 53 to actuaries and to the public, “the ASB quickly realized that there are significant differences of opinion within the profession regarding certain aspects of ratemaking, including pricing, price optimization methodologies, and rate filing requirements, that would need to be reconciled before a comprehensive standard of practice on ratemaking could be developed. Therefore, to create a standard of practice for the core aspects of ratemaking that could be issued in a reasonable amount of time, the ASB has chosen to develop this ASOP to pertain solely to the development or review of future cost estimates for prospective property/casualty risk transfer and risk retention.”

The sudden and unexpected rescission of the CAS SOP on Ratemaking leaves actuaries with no actuarial standards or Principles as respects final rates, the only rates that really matter to the public and to regulators. Today, an actuary could make a filing with the state, fully complying with current ASOPs and, at the end, pick any rate to file the actuary wanted, including rates adjusted by a price optimization, consumer lifetime value or other algorithms or just picked out of the air. The actuary could then properly confirm to the regulator that this rate, untethered from any cost-based indication “meets all actuarial standards.” This puts the regulator in an untenable position and, in some cases at least, unable to determine exactly what is going on with the filed rates being reviewed since disclosure of the uses of new algorithms in rate filings is often obscure or even completely missing.
TO: Casualty Actuarial Society (CAS) Board of Directors  
Sent via email to Laura Stout

FROM: Phillip Vigliaturo, Chair  
Casualty Actuarial and Statistical (C) Task Force

DATE: March 9, 2021

SUBJECT: Comments on the CAS Board of Director’s Decision to Rescind Statements of Principles

On December 22, 2020, the Casualty Actuarial Society (“CAS”) announced that its Board of Directors unilaterally rescinded the following Statements of Principles:

- Statement of Principles regarding Property and Casualty Insurance Ratemaking (May 1988)
- Statement of Principles regarding Property and Casualty Valuations (September 1989)
- Statement of Principles regarding Property and Casualty Unpaid Claims Estimates (November 2014)

Not only was the decision unilateral, it was seemingly made without any notice to the CAS membership. We are disappointed that this rescindment occurred without notice, open discussion or input from the membership. For the reasons set forth in this letter, the NAIC’s Casualty Actuarial and Statistical Task Force (“CASTF”) requests the reinstatement of the Statement of Principles (“SOP”) regarding Property and Casualty Insurance Ratemaking.

We are not aware of another document as concise and accessible as the Ratemaking SOP that so clearly and completely ties rates to risk. A generation of actuaries have reviewed, relied upon and cited the ratemaking principles since its adoption in 1988. While the document was not prescriptive or exhaustive, it provided clearly stated principles for any and all insurance professionals to consider with regard to ratemaking. For this very reason, many regulatory actuaries relied on the document for a common foundation in discussions with industry representatives whether or not they were credentialed actuaries.

The rescindment of the Ratemaking SOP provides the impression that the principles are no longer viewed as valid by the actuarial profession. We find this especially troubling in an environment in which characteristics used by insurers in pricing are being challenged, quite publicly, for their perceived lack of a relationship to risk. The Ratemaking SOP complemented state laws that require rates to be related to risk and which provide regulators their authority to challenge rates that are not. The rescindment might open the door to attacks on these rate regulatory laws.

While it has been argued that aspects of the Ratemaking SOP are repeated in various Actuarial Standards of Practice (“ASOPs”), parties that are not closely affiliated with the CAS are challenged to search, read through and comprehend multiple ASOPs, which are often issue-specific. Much of the utility of the Ratemaking SOP was in its simplicity and focus; it applied to all aspects of actuarial ratemaking – a true principles statement – and provided value even if duplicative of certain parts of different ASOPs. For example, when testifying before a legislative committee or explaining a concept to a consumer, referring to multiple ASOPs risks the audience’s attention and comprehension as opposed to a singular SOP document that is credible, concise and understandable to a layperson.

We recognize that there are opportunities to modernize the SOP for recent developments in ratemaking such as price optimization, artificial intelligence and predictive models. These developments can be addressed with amendments to the SOP rather than a wholesale rescindment of the document. In fact, these developments support the need for the rescinded ratemaking principles to ensure that non-actuaries leading these developments understand the actuarial profession’s position on the need for risk-based rating.

In closing, we submit that the Statement of Principles regarding Property and Casualty Insurance Ratemaking is too important of a document and too widely cited and relied upon to be rescinded at this time. We urge you to reverse the rescindment.

Cc: Kris DeFrain, NAIC

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Current Research

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<th>Project</th>
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<td>Uninsurable risk with a focus on BI</td>
<td>Copy editing</td>
<td>Q1 2021</td>
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<td>Demand for Microinsurance</td>
<td>Final draft awaited</td>
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<td>The peer-to-peer insurance market</td>
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<td>Credibility for excess insurance layers</td>
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<td>Flood models using public data</td>
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<td>Cannabis legislation and auto loss frequency (joint project with CIA)</td>
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<td>Guide to IFRS 17 for US actuaries</td>
<td>Working group underway</td>
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<td>Claims analysis of social inflation</td>
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Future Research

Although the CAS is considering a number of future research projects, there are no open calls for authors or researchers at present.

Recent CE

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<td>GIRO Session: Effective actuarial communication through storytelling</td>
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<td>CAS webinar: Separate Impact and Rate Differentiation: A New Paradigm</td>
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<td>Revisiting the Methodology of Actuarial Science</td>
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<td>Autonomous Trucking</td>
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Upcoming CE

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<td>Predictive Modelling – A Regulator's Perspective</td>
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<td>Social Inflation and Emerging Mass Torts – Now, Next and Beyond</td>
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<td>Telematics – the Future for Auto Insurance?</td>
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<td>Seminar on Reinsurance</td>
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Highlights of Recent Research Reports

- **Catastrophe & Climate Strategic Research Program Newsletter**
  - January 2021 edition
  - [https://www.soa.org/publications/catastrophe-climate/](https://www.soa.org/publications/catastrophe-climate/)
  - Overview of SOA’s 2021 Environmental Risk Series of reports
  - Summary of key catastrophe risk articles
  - Relationship between Residential Losses and Hurricane Winds: Role of the Florida Building Code

- **Actuarial Weather Extremes**
  - Monthly reports that identifies and examines unusual or extreme single-day or multi-day weather events across North America
  - [https://www.soa.org/resources/research-reports/2019/weather-extremes/](https://www.soa.org/resources/research-reports/2019/weather-extremes/)
  - January 2021: Precipitation / Snow / Ice extremes; Persisting Drought
  - February 2021: Extreme cold

- **Tool for Mapping and Graphing Google’s Mobility Dataset**
  - Large focus on change in mobility and movement across all insurance lines of business
  - Google mobility data packed in an easy to use, view and graph format
  - [https://www.soa.org/resources/research-reports/2020/google-mobility-data/](https://www.soa.org/resources/research-reports/2020/google-mobility-data/)
SURPLUS LINES (C) TASK FORCE

The Surplus Lines (C) Task Force did not meet at the Spring National Meeting.
TITLE INSURANCE (C) TASK FORCE

Title Insurance (C) Task Force March 16, 2021, Minutes

Title Insurance (C) Task Force Feb. 23, 2021, Minutes (Attachment One)
The Title Insurance (C) Task Force met March 16, 2021. The following Task Force members participated: Judith L. French, Chair, represented by Michelle Brugh Rafeld (OH); David Altmaier, Vice Chair, represented by Jeffrey Joseph (FL); Peni Itula Sapini Teo represented by Elizabeth Perri (AS); Karima M. Woods represented by Angela King (DC); Colin M. Hayashida represented by Martha Im and Paul Yuen (HI); Vicki Schmidt represented by Heather Droge (KS); James J. Donelon represented by Warren Byrd (LA); Kathleen A. Borrane represented by David Zitterbart (MD); Chlora Lindley-Myers represented by Carrie Couch (MO); Troy Downing and Tyler Spady (MT); Mike Causey represented by Timothy Johnson (NC); Bruce R. Ramge (NE); Marlene Caride represented by Randall Currier (NJ); Russell Toal (NM); Jessica K. Altman represented by Michael McKenney (PA); Raymond G. Farmer represented by William Starks (SC); Larry D. Deiter represented by Maggie Dell (SD); Scott A. White represented by Mike Beavers (VA); and Michael S. Pieciak represented by Kevin Gaffney (VT). Also participating was: Adam Martin (UT).

1. **Adopted its Feb. 23 Minutes**

The Task Force met Feb. 23 and took the following action: 1) adopted its Oct. 21, 2020, minutes; 2) discussed its 2021 work plan; and 3) heard a presentation on effects of the COVID-19 pandemic on the title insurance industry.

Mr. Byrd made a motion, seconded by Superintendent Toal, to adopt the Task Force’s Feb. 23 minutes (Attachment One). The motion passed unanimously.

2. **Discussed its Revised 2021 Work Plan**

Ms. Rafeld stated that the revised list of work plan ideas for 2021 is as follows:

1. **Explore the effects of the COVID-19 pandemic on the title insurance industry through presentations.**
   a. Presentation, Part 1 from the American Land Title Association (ALTA) on the Feb. 23 call.
   b. Presentation, Part 2 from ALTA on the March 16 call.
   c. Possible presentations from other interested parties.
   d. Produce a brief summarizing the findings.

2. **Revise the Title Insurance Consumer Shopping Tool Template.**
   a. Discuss comment letters on revision suggestions during the March 16 call.
   b. Member drafting sessions begin March 23.
   c. Drafting members: Ms. Rafeld; Mr. Joseph and Anoush Brangaccio (FL); Mr. Byrd; Marianne Baker (TX); Sharon Richetti (MT); Mr. Johnson; Erica Bailey (MD); Dorcas Voyles (FL DFS); Marjorie Thompson (MO); and Mr. Beavers.

3. **Monitor issues and developments occurring in the title insurance industry, including profitability and claims settlement.**
   a. Presentation by AM Best on the latest Best’s Market Segment Report on the U.S. Title Insurance Market on TBD.
   b. Presentation by Demotech on their recent defalcation study on TBD.
   c. Presentation by consumer representatives on consumer protection issues they are hearing on TBD.
   d. Potential presentation by the Federal Bureau of Investigation (FBI) on cybercrime and business email compromises.
   e. Explore a presentation regarding criminal investigations of wire fraud.

4. **Assist the Antifraud (D) Task Force in combating fraud through joint calls and meetings.**
   a. A request was sent Jan. 28 to Antifraud (D) Task Force members asking them to share reports of title insurance fraud and/or mortgage fraud trends in their states. Responses will be used to develop sharing opportunities though future calls and meetings.
5. Will consult with the Consumer Financial Protection Bureau (CFPB) through regulator-only and/or open calls with the CFPB.
   a. Presentation from the CFPB on recent changes and priorities.
   b. Determine if joint regulator-only calls are needed.

6. Determine the role of the Task Force in exploring race and insurance implications in the title insurance space.
   a. Confer with the Special (EX) Committee on Race and Insurance and the Property Casualty Insurance (C) Committee.

Ms. Rafeld stated that the first work plan item remains to explore the impact of the COVID-19 pandemic on the title insurance industry though presentations, such as the one ALTA is finishing during the current meeting. Based on the Task Force’s mutual agreement on its Feb. 23 call, the work plan now also includes potential presentations from other interested parties, such as consumer representatives, title underwriters, and state insurance regulators. This includes a suggestion to take a deeper look into how consumers responded to virtual closings.

The second work plan item remains to update the Title Insurance Consumer Shopping Tool Template through member drafting sessions beginning March 23. Nine states have signed on to participate in the drafting sessions. Thus far, two states have submitted suggested revisions. Ms. Rafeld also discussed Birny Birnbaum’s (Center for Economic Justice) suggestion to conduct testing on the Title Insurance Consumer Shopping Tool Template. She indicated that while the suggestion is not without merit, the specific charge of the Task Force is to make updates to include information regarding fraud. She suggested the Task Force discuss any additionally proposed revisions when it discusses its 2022 charges.

The third work plan item now includes the addition of “monitor issues and developments occurring in the title insurance industry, including profitability and claims settlement.” This includes presentations by AM Best on its latest Best’s Market Segment Report, Demotech on its recent defalcation study, and consumer representatives on any related issues. Additionally, as recommended by Virginia, the Task Force will reach out to the FBI to hear about cybercrime and business email compromises, which is one of Virginia’s biggest issues. Other presentations on criminal investigations of wire fraud may be contemplated too.

The fourth work plan item is to assist the Antifraud (D) Task Force in combating fraud through future calls and meetings based on responses received from Antifraud (D) Task Force members on trends in their states.

Under the fifth work plan item, the Task Force will still consult with the CFPB to receive an update. Based upon the outcome of discussions with the Antifraud (D) Task Force, the Title Insurance (C) Task Force may hold regulator-only calls with the CFPB.

The sixth work plan item relates to the suggestion by some Task Force members to look into race and insurance implications in the title insurance space. The Special (EX) Committee on Race and Insurance has several workstreams. The third workstream is charged to examine and determine which practices or barriers exist in the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups in the property/casualty (P/C) line of business. This workstream is currently determining if and what tasks it should delegate to specific subject matter expert (SME) groups. The workstream plans to take up the Task Force’s request for clarification on what role it should play in this area on a call in the near future. An update will be provided once a decision has been communicated by the Committee.

Mr. Byrd asked if the role of exploring race and insurance would focus on more minorities working in the field of title insurance or on the sale of a policy in areas that may be populated by minorities. Ms. Rafeld stated that it is her general impression that the Task Force members want to look into all of the issues in this space.

Steve Gottheim (ALTA) said ALTA is finalizing new base policy forms, and he would be happy to present on them during a future Task Force meeting. Ms. Rafeld stated that she would add the proposed presentation to the work plan for 2021.

3. Heard Part Two of a Presentation on the Effects of the COVID-19 Pandemic on the Title Insurance Industry

Mr. Gottheim, Mary Payne Thomas (Stewart Title Guaranty Company), and Nick Hacker (Guaranty & Title Co.) continued their presentation that began during the Feb. 23 meeting. The early days of the pandemic brought much uncertainty. Most companies experienced a 40% drop in volume. County closures created barriers to conducting searches and closing deals. This was followed by a rebound in volume, driven by mortgage refinances. The industry met these challenges and worked to ensure that closings occurred safely and efficiently. Costs increased due to personal protection equipment (PPE) purchases and digital
closings, which rose by over 500%. Flexible contingency plans were put in place to address staffing challenges presented by infection.

2020 was an unusual year with staggering levels of volume. The outlook for 2021 is also very strong if interest rates remain low. Existing home sales increased to $5.65 million in 2020, up from $5.34 million in 2019. They are anticipated to increase again to $6.04 million in 2021 before dropping to $5.7 million in 2022. New home sales increased to $811,000 in 2020, up from $682,000 in 2019. They are anticipated to increase again to $860,000 in 2021 before dropping to $851,000 in 2022. New purchase mortgages and refinances trend accordingly with existing and new home sales. The federal government is staying foreclosures and evictions though June, and states have similar limits in place. Once the limits are no longer in place, the market will face distress. Black Knight reported that 2.7 million Americans have active forbearance plans, with 308,000 already in modifications. However, only 1% of commercial sales are distressed, which is a significant difference from 2010, when about 20% were distressed. It should be noted that in nonjudicial foreclosure states, title companies are often listed as the trustee in a consumer’s mortgage. The current low foreclosure rate brings additional reserving uncertainty. The mix of claims is changing with more people at home. Neighbor disputes and issues related to renovations are more prevalent. Delayed mail delivery and service is also affecting the receipt of policies and claims notifications.

State insurance regulators have helped ease the strain of the pandemic by relaxing in-person audit or examination requirements. This includes allowing more audits to be conducted electronically. State insurance regulators have also waived notary and original signature requirements on filed forms. Additionally, education and testing for licensing was allowed to be done virtually.

The title insurance industry also dedicated time, effort and money to strengthening communities through charitable acts like donations of PPE, food and other services. In October 2020, ALTA launched the ALTA Good Deeds Foundation to bolster charitable efforts of its members in its communities. The Foundation’s aid goes to help those adversely affected by national emergencies, such as the COVID-19 pandemic, or with housing needs.

Ms. Rafeld stated that the presentation was very eye opening on the level of creativity the industry was forced to use as soon as the pandemic hit.

Mr. Byrd asked if the additional costs incurred due to the pandemic were passed on to the participants in the closing. Mr. Hacker said the costs were not passed on, and the pricing has remained the same for over a year. Ms. Thomas said costs in the early days of the pandemic included innovative things like partnering with local distilleries for hand sanitizer because PPE was not readily available during this time.

Mr. Martin asked if there is the potential for loans and foreclosures to cause significant fraud issues similar to what happened during the Great Recession. Mr. Hacker said it is a distinct worry because the foreclosures that came to fruition during the Great Recession were the result of fraud that happened during the run up to that recession. Additionally, a lot of fraud claims during the Great Recession related to issues with the mortgage modification process. There is a lot of work going on to find ways to speed up the modification process, including with the Federal National Mortgage Association (Fannie Mae) and the Federal Home Loan Mortgage Corporation (Freddie Mac). The faster a consumer is transitioned from initial contact into active modification, the higher the success.

Ms. Thomas said there is the expectation of increased claims from fraudulent foreclosures. The industry must deal with these new issues while also still managing ongoing fraud issues, such as wire fraud, that has been sustained due to the increasing savvy of fraudsters. State insurance regulators should be aware of the potential for increased consumer complaints, since many complaints are centered around how a claim has been handled and how claims have increased.

Mr. Byrd asked for clarification on the process that occurs between a foreclosure and a title insurance issue. Ms. Thomas said there are many different ways, including intervening loans that might result in a lender claim during the foreclosure process, someone filing a claim to avoid foreclosure, and simply being included as a party because the company was involved in the policy issued and therefore listed as the trustee on the deed of trust. Mr. Gottheim said there are also circumstances beyond the standard types of claims just mentioned. One common way closure can add to the claims experience is an issue not being discovered until someone runs the title for foreclosure for the lenders. Mr. Hacker said there can also be legal description disputes. His company had a recent claim in which the mortgage encumbered a small piece of land that was not owned by the property owner. This resulted in the purchase of an additional four feet of the neighbor’s land during the foreclosure process.

Mr. Byrd said Louisiana is introducing legislation to remove the reference to “on-site audit” in its law so audits may also be done electronically.

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4. **Discussed Comments Received on Revision Suggestions to the Title Insurance Consumer Shopping Tool Template**

Ms. Rafeld stated that following the Feb. 23 call, a request was sent out for members, interested state insurance regulators, and interested parties of the Task Force to submit revision suggestions for the *Title Insurance Consumer Shopping Tool Template* for the drafting group to consider in its drafting sessions by March 12. Revision suggestions were received from Virginia and Louisiana. Virginia and Louisiana’s suggested edits included the following:

**Virginia**
- Revising the “If you’ve found the perfect home or property” subsection to: 1) combine the fifth and sixth bullets to: “You’ll buy homeowners insurance through a licensed property and casualty insurance agent who can also assist you in determining if you need additional coverages, such as flood or earthquake”; and 2) add that closings may be held in person or virtually.
- Revising the “If you’re refinancing your home or property” subsection to identify lenders and owners.
- Revising the “Two Types of Title Insurance—Owner’s and Lender’s Policies” section to note that coverage can also apply to heirs.
- Revising the “What Doesn’t Title Insurance Cover?” section to add a comment that encourages consumers to contact their title insurance company if there are any questions regarding coverage of a possible claim.
- Revising the “The Right to Choose Your Own Title Agent/Company” section to delete the reference to “in the phone book.”
- Revising the “Closing Agents” section to include banks and real estate brokers handling some settlements.
- Revising the “Shop Around for Title Insurance and Closing Services” section to mention some states allow for negotiated rates.
- Revising the “Final Tips to Remember” section to add fraud tips from the FBI and red flags and prevention methods for business email compromises (BECs), personal email compromises, phishing, etc.

**Louisiana**
- Replacing “agent” with “producer” and adding clarifying language to include “property” in addition to “home” throughout the document.
- Revising the “Introduction” section to change “good” to “wise” and move “however” to the beginning of the sentence.
- Revising “The Difference Between Title and Homeowners Insurance” section to create separate bullets for multi-sentenced bullets and support the statement on how a homeowners policy is paid and renewed.
- Adding a “The Role of Fraudsters in Real Estate Transactions” section.

Mr. Beavers stated that his proposed revisions focus primarily on information to assist consumers when they have an issue with fraud, such as email compromise.

Mr. Byrd stated that his proposed revisions include considering if “producer” should be used in place of “agent,” changing the format, and adding a new section on fraud.

Ms. Rafeld asked that any additional proposed revisions be submitted to NAIC staff by March 19.

Having no further business, the Title Insurance (C) Task Force adjourned.
Title Insurance (C) Task Force
Virtual Meeting
February 23, 2021

The Title Insurance (C) Task Force met Feb. 23, 2021. The following Task Force members participated: Judith L. French, Chair, represented by Michelle Brugh Rafeld (OH); David Altmaier, Vice Chair, represented by Jeffrey Joseph and Anoush Brangaccio (FL); Lori K. Wing-Heier (AK); Karima M. Woods represented by Angela King (DC); Colin M. Hayashida represented by Martha Im (HI); Vicki Schmidt represented by James Norman (KS); James J. Donelon represented by Charles Hansberry (LA); Kathleen A. Bittner represented by David Zitterbart (MD); Grace Arnold represented by Phil Vigliaturo (MN); Chlora Lindley-Myers (MO); Troy Downing (MT); Mike Causey represented by Timothy Johnson (NC); Bruce R. Range (NE); Marlene Caride represented by Randall Currier (NJ); Russell Toal (NM); Jessica K. Altman represented by Maggie Dell (SD); Scott A. White represented by Mike Beavers (VA); and Michael S. Pieciak represented by Kevin Gaffney (VT).

1. Adopted its Oct. 21, 2020, Minutes

The Task Force met Oct. 21, 2020, to adopt its 2021 proposed charges.

Superintendent Toal made a motion, seconded by Ms. Brangaccio, to adopt the Task Force’s Oct. 21, 2020, minutes (see NAIC Proceedings – Fall 2020, Title Insurance (C) Task Force, Attachment One). The motion passed unanimously.

2. Discussed its 2021 Work Plan

Ms. Rafeld stated that the proposed list of work plan ideas for 2021 is as follows:

1. Will explore the effects of the COVID-19 pandemic on the title insurance industry through presentations.
   a. The first presentation will be from the American Land Title Association (ALTA) during the Feb. 23 meeting.

2. Revise the Title Insurance Consumer Shopping Tool (Shopping Tool) template through member drafting sessions beginning March 23.
   a. Please notify NAIC staff Anne Obersteadt (aobersteadt@naic.org) by March 12 if you would like to participate.
   b. The drafting group would like to solicit revision suggestions for its consideration. Please submit revision suggestions to NAIC staff Anne Obersteadt (aobersteadt@naic.org) by March 12.

3. Will assist the Antifraud (D) Task Force in combating fraud through joint calls and meetings.
   a. A request was sent Jan. 28 to Antifraud (D) Task Force members asking them to share reports of title insurance fraud and/or mortgage fraud trends in their state. Responses will be used to develop sharing opportunities through future calls and meetings.

4. Will consult with the Consumer Financial Protection Bureau (CFPB) through regulator-only calls with the CFPB.

Ms. Rafeld stated that the first item in the proposed work plan should also include inviting consumer representatives, title underwriters, and state insurance regulators to provide presentations on this topic. She stated that Birny Birnbaum (Center of Economic Justice—CEJ) brought up some very interesting questions related to virtual closings in his submitted comment letter. Answering these questions, concerns or issues consumers have raised since the pandemic through a presentation from Mr. Birnbaum and other consumer representatives would be beneficial to the Task Force.

On its last call in 2020 to discuss its 2021 proposed charges, the Task Force decided it should prioritize updating the Shopping Tool. As such, the second work plan item is to do so through member drafting sessions beginning March 23. Members of the Task Force interested in participating were directed to notify NAIC staff by email by March 12. Also, to get the drafting process started, revision suggestions from members, interested state insurance regulators, and interested parties for the drafting group to consider in its drafting sessions were requested to be submitted by March 12 to NAIC staff.

Mr. Birnbaum stated that the Task Force should take an analytic approach to evaluate how the Shopping Tool should be updated by establishing criteria that helps determine what is or is not useful. Criteria includes determining how or if the Shopping Tool
has been used by states and consumers. It also includes evaluating if the format needs to be revised and if the distribution channel needs improvement.

The third work plan item meets the Task Force’s charge to assist the Antifraud (D) Task Force in combating fraud. On January 28, a request was sent out to Antifraud (D) Task Force members asking them to share reports of title insurance fraud and/or mortgage fraud trends in their state. NAIC staff compiled the responses, and at a high level, states reported some of the following issues: consumer protection letter (CPL) concerns, defalcations, fraudulent settlement transactions, wire fraud complaints, cybercrime, improper rebating and discount offerings, payment of unlawful compensation to realtors, and using higher priced owners’ policies of title insurance without notice or consent of the policyholder. Including a regulator-only call with Antifraud (D) Task Force members to discuss these issues in greater detail could be helpful in determining if further such meetings are needed.

The fourth agenda item is designed to meet the Task Force’s charge to consult with the CFPB. An email was sent to the CFPB about this charge and the Task Force’s desire to work with them once again. If the CFPB is open to the suggestion, receiving an update from them on a future call would be very helpful. There may even be a need to have regulator-only calls with the CFPB and the Antifraud (D) Task Force.

Ms. Rafeld stated that AM Best sent NAIC staff its recently released *Market Segment Outlook: US Title Insurance* report. She proposed that hearing a presentation from AM Best on the report may address the comments received from Mr. Birnbaum on the need to examine title insurance profitability. She further proposed that Mr. Birnbaum’s questions on race and title insurance be referred to the Special (EX) Committee on Race and Insurance since they fall in line with the charges that the Committee is exploring.

Superintendent Toal stated that he has concerns in referring race and insurance issues to the Special (EX) Committee on Race and Insurance. He stated that it deserves the attention of the Title Insurance (C) Task Force. Mr. Birnbaum stated that the CEJ’s preference was to keep the issue at the Task Force level and inform the Committee that this is the Task Force’s preference. The Committee is examining global issues in this area. The Task Force should look into title insurance specific considerations. Steve Gottheim (ALTA) stated that he agrees with Mr. Birnbaum because there are many differences in the way title insurance operates, including in its rate structures and the proxies it uses for risk. Ms. Rafeld stated that the proposed 2021 work plan is a fluid document, and she said she would examine before the next call whether there is a place within the Task Force’s charges that the race and insurance issues could be taken up. She also stated that she would reach out to the Committee NAIC staff support to get feedback on how best to coordinate.

Mr. Gottheim stated that ALTA is in the final stages of updating its policy forms, and it would like to present on the updates to the Task Force during the Summer National Meeting or a later meeting.

Mr. Beavers requested that the AM Best report be distributed to the Task Force. Ms. Rafeld said NAIC staff would distribute it to the Task Force after the meeting.

3. Heard Part One of a Presentation on the Effects of the Pandemic on the Title Insurance Industry

Mr. Gottheim, Mary Payne Thomas (Stewart Title), and Nick Hacker (Guaranty & Title Co.) outlined how the title insurance industry was able to pivot its services during the early stages of the pandemic. In mid-March 2020, many states issued stay-at-home orders, and companies were suddenly left to figure out how to operate remotely. Volatile swings in demand in these early weeks drove uncertainty on how the pandemic and the resulting recession would affect home buying and the title business, potentially leading to furloughs. A number of companies saw volume drop over 40% in March and early April. Over five thousand title companies took Paycheck Protection Program (PPP) loans. Volume then spiked from new interest in home ownership and low interest rates.

The industry met these challenges and worked to ensure that closings occurred safely and efficiently. Closing options employed were in-person with accommodations for social distancing, curbside where the customer remained in the car during the closing, and remote via the internet with a webcam. Notarization methods used include: 1) remote online notarization (RON) of electronic documents with use of multi-factor authentication; 2) remote online notarization of paper documents (PRON) delivered via mail or courier with use of multi-factor authentication; 3) remote notarization of paper documents via audio-video (RIN); 4) traditional wet-in-person notarization (TWIN); and 5) in-person notarization of electronic documents (PEN). Twenty-nine states had passed online notary legislation by November 2020. Online closing is useful, but it is still cumbersome due to the multi-factor authentication needed to keep the transaction safe and the large number of partners involved in the
process.

There were many operational logistics that had to be worked out to produce a policy and close remotely. This included how to access needed public records when county recording offices are shut down, operating remotely, or operating on a skeleton staff. Some offices did not provide the ability to do a title search or record a document. Offices providing online services still came with the challenge of getting land records with sufficient history. Companies were faced with making a risk judgment on how comfortable they were with the limited data available to do the transaction. Since the operating procedure at each county office varied greatly, constant monitoring was needed to evaluate each individual county situation. It was of great help when several states partnered with the U.S. Department of Homeland Security and the General Services Administration (GSA) to put out a list of central services that included title insurance and county recorders.

To stay open, companies incurred many extra costs, including personal protection equipment—masks, sanitizer, Plexiglas, single-use pens—for employees and customers, new equipment to allow work from home and digital closing, internet access, and training on new protocols and technology. Not every job could be done remotely. Contingency plans were developed to keep operations going when an employee had to quarantine. This was especially challenging in rural operations where there may have been only one person doing that job with the nearest overflow staff two hours away. Safety protocols with little information, such as how long the coronavirus lasts on paper, also had to addressed.

The innovation that occurred out of necessity was spectacular in the industry. For example, there were companies that partnered with local distilleries to produce hand sanitizer. Other local offices rented wedding tents to set up drive through closings. Much of the innovation was due to technology. Technology will continue to be important to innovation in the title industry. However, technology is also driving up the cost of transactions. RON on average doubles staff time. These systems come with per transaction fees, require more training, new equipment, and other systems to be able to set it up. The industry’s challenge will be providing local service to home buyers (or homeowners refinancing) and balancing it with the needs of its staff.

Ms. Rafeld stated that the presentation had been very eye opening on the level of creativity the industry was forced to use as soon as the pandemic hit. She invited Mr. Gottheim, Ms. Thomas and Mr. Hacker to continue their presentation at the Task Force’s March 16 call.

Having no further business, the Title Insurance (C) Task Force adjourned.
WORKERS’ COMPENSATION (C) TASK FORCE

Workers’ Compensation (C) Task Force March 15, 2021, Minutes ................................................................. 8-69
Compensation Claims Related to COVID-19 (Attachment One) ........................................................................ 8-73
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Workers’ Compensation (C) Task Force
Virtual Meeting (in lieu of meeting at the 2021 Spring National Meeting)
March 15, 2021

The Workers’ Compensation (C) Task Force met March 15, 2021. The following Working Group members participated: Lori K. Wing-Heier, Chair, Anna Latham and Michael Ricker (AK); Glen Mulready, Vice Chair, represented by Kim Bailey, Cuc Nguyen and Andrew Schallhorn (OK); Alan McClain represented by Jimmy Harris (AR); Evan G. Daniels represented by Tom Zuppan (AZ); Ricardo Lara represented by Yvonne Hauscarriague, Giovanni Muzzarelli and Mitra Sanandajifar (CA); Andrew N. Mais represented by George Bradner and Wanchin Chou (CT); Karima M. Woods represented by David Christhilf and Angela King (DC); David Altmair represented by Sandra Starnes (FL); John F. King represented by Steven Manders (GA); Colin M. Hayashida represented by Randall Jacobson (HI); Dean L. Cameron represented by Michele MacKenzie, Randy Pipal and Aaron White (ID); Dana Popish Severinghaus represented by Judy Mottar and Benjamin Rekart (IL); Vicki Schmidt represented by Heather Droge and Brenda Johnson (KS); James J. Donelon represented by Warren Byrd and Tom Travis (LA); Eric A. Cioppa, Sandra Darby and Robert Wake (ME); Grace Arnold represented by Tammy Lohmann and Phil Vigliaturo (MN); Chlorinda Linley-Myers, Cynthia Amann and Jo LeDuc (MO); Mike Causey represented by Fred Fuller and Michelle Osborne (NC); Marlene Caride represented by Chanell McDevitt and Mark McGill (NJ); Barbara D. Richardson represented by Gennady Stolyarov (NV); Andrew R. Stolfi represented by TK Keen (OR); Jessica K. Altman represented by Michael McKenney (PA); Elizabeth Kelleher Dwyer represented by Beth Vollucci (RI); Raymond G. Farmer represented by Michael Schull and Michael Farmer (SC); Larry D. Deiter and Maggie Dell (SD); Michael S. Pieciak represented by Kevin Gaffney and Pat Murray (VT); and James A. Droril and Tonya Gilespie (WV). Also participating were: Amanda Harlow-Felder and John Wells (MS); Connie Adams, Marianne Baker and Nicole Elliott (TX); and Tracy Klausmeier (UT).

1. **Adopted its 2020 Fall National Meeting Minutes**

Mr. McKenney made a motion, seconded by Ms. Nakasone, to adopt the Task Force’s Nov. 16, 2020 (see NAIC Proceedings—Fall 2020, Workers’ Compensation (C) Task Force) minutes. The motion passed.

2. **Heard a Presentation from the IAIABC on COVID-19 Workers’ Compensation Claims**

Jennifer Wolf (International Association of Industrial Accident Boards and Commissions—IAIABC) said they have been collecting data regarding COVID-19 workers’ compensation claims. She said the IAIABC has been working with their research and standards committee for the past several years to collect claims information related to their workers’ compensation experience from states and provinces. The basic measures being collected include: 1) the number of claims received each year; 2) the number of fatalities; 3) the denial rates; and 4) the rates per 100,000 workers in those claims. Ms. Wolf said they used this model to create a data call for workers’ compensation claims related to COVID-19.

Ms. Wolf said the IAIABC Claims Measures survey seeks to provide a broad overview of workers’ compensation claims metrics across North American jurisdictions for injury and fatality data. She said the IAIABC’s first report was published in the summer of 2020 and includes five basic measures of claims across the states and provinces. Ms. Wolf said the survey is a good reference in helping to understand some of the data reporting differences across jurisdictions. She said the data reporting differences are important and meaningful when looking at the COVID-19 workers’ compensation claims that were reported.

Ms. Wolf said the IAIABC began having informal discussion sessions in April 2020 with jurisdictional administrators about their experiences and challenges related to COVID-19. She said that during those calls, there was a lot of informal sharing about the COVID-19 claims that states were beginning to see. As part of the discussion, the IAIABC began to collect and aggregate this information. The claims numbers are taken from the first report of injury data that is reported by claims administrators to the states. The IAIABC collected claims information from 19 states throughout 2020. Ms. Wolf said this information came from claims that were received from late February 2020 through December 2020. She said this data was collected through the end of January 2021, so there may still be a few claims outstanding through the end of last year. Ms. Wolf said this data provides a good snapshot of the COVID-19 claims experience for the 19 states. Across the 19 states, there were almost 260,000 COVID-19 workers’ compensation claims reported. Claims reported by California, Florida and Texas represented almost 70% of the total COVID-19 claims reported.

Ms. Wolf said one of the things discussed at the IAIABC and across the workers’ compensation industry is the interest in understanding the denial rate of workers’ compensation claims. She said they did not calculate the median across all 19 states because not all of the states collect denial information in the same manner. Ms. Wolf said the median denial rate across 15 states was 35.4%, which is higher than the denial rate of other types of workers’ compensation claims. She said as states looked
at the data more closely, they found that a significant portion of the COVID-19 claims denied were attributed to a negative COVID-19 test.

Ms. Wolf said one significant trend seen in 2020 was that states started using their first and subsequent report of injury data to create dashboards and analytic reports on COVID-19 claims. She said the California Workers’ Compensation Institute (CWCI) created an interactive dashboard that is updated frequently with workers’ compensation claims data. This data has several different measures and allows users to create customized views based on a number of different variables. Ms. Wolf said this interactive database is an example of how workers’ compensation claims data can be used to present information in a digestible and user-friendly way. This interactive data base is being updated more frequently than many of the injury and illness reports that have been presented in the past.

Ms. Wolf said Florida, Kansas, Minnesota, Montana, Ohio, Texas, Virginia and Washington sent weekly or monthly reports to their governors or other administration officials related to COVID-19 workers’ compensation claims. She said many of these reports were shared informally with the workers’ compensation industry and were available publicly. Ms. Wolf said this is an example of states using the data they are collecting to provide a more up-to-date analysis. She said she believes these kinds of efforts will be replicated in the future, giving stakeholders a better understanding of workers’ compensation claims experience within their states.

Ms. Wolf said the IAIABC collected information regarding the number of reported workers’ compensation claims coded to COVID-19 for 19 different states. She said the chart shown does not include California, because they have by far the largest number of workers’ compensation claims related to COVID-19 (Attachment One). Ms. Wolf said California saw more than 113,000 workers’ compensation claims, while Texas (the second highest number of COVID-19 claims) had more than 30,000 workers’ compensation cases filed. States such as Iowa and Maryland had less than 2,500 COVID-19 workers’ compensation claims files.

Ms. Wolf said it is important to understand that these are claims counts generated by the first report of injury received by the states and that there are many differences in reporting requirements across jurisdictions. She said this will account for some of the differences when trying to compare across jurisdictions. Ms. Wolf said some states require the reporting of all claims, while other states require only the reporting of lost-time claims. She said, for example, Florida and Michigan only require the reporting of claims that have a lost-time component. Ms. Wolf said there are also significant variations in the waiting periods across states, which will have an impact on some of the numbers of claims being reported.

Ms. Wolf said one of the questions the IAIABC had regarding COVID-19 workers’ compensation claims was whether they would see a difference in claims across states that had implemented a COVID-19 presumption versus states that had not implemented a presumption. She said there was really no discernable link between the number of COVID-19 workers’ compensation claims within states that implemented presumptions than within states that did not implement presumptions. Ms. Wolf said it is important to understand that presumptions are not created equal, and they vary in scope and the industries and worker’s classes they cover.

Ms. Wolf said another way to view this information is to look at how significant COVID-19 claims are in relation to all workers’ compensation claims reported within a jurisdiction. She showed a chart (Attachment Two) that reflected the percentage of COVID-19 claims compared to all of the reported workers’ compensation claims in 2020. The percentage varies from less than 5% of the claims in Georgia to more than 30% of the claims in Florida and Michigan. Ms. Wolf said the differences in reporting requirements could have an impact on the percentage. She said Florida only requires lost-time claims to be filed, while Georgia requires all claims be filed; this could account for one of the differences in terms of percentage. Ms. Wolf said the median across the 16 states shown was 10%, indicating that 10% of the workers’ compensation claims were COVID-19 claims.

Ms. Wolf said there has been a lot of interest and discussion regarding denial rates for workers’ compensation claims related to COVID-19. The denial rates range from 4% in Michigan and Missouri to as high as 63% in Colorado. She said there has been a lot of speculation that there were workers who filed claims based on exposure, or the fact they had to go into isolation or quarantine, because a colleague may have had COVID-19 and the claim represented a preemptive measure; if a COVID-19 test came back negative, this would lead to a claim denial. Director Wing-Heier said Alaska also experienced this.

Mr. Bradner asked if the IAIABC was also looking at self-insured entities in the data. Ms. Wolf said self-insured data was included in their data. She said the data for all the information she is reporting on was from all claims reported to the states by both insured and self-insured employers. Ms. Wolf said some states have seen some difference in denial rates from insured employers versus self-insured employers. Mr. Bradner asked how IAIABC was getting data from the self-insured entities and asked how comfortable the IAIABC was with the data received. Ms. Wolf said this data is based on the first report of injuries.
that were reported to the state. She said all claims have to be reported to the state regardless of whether a business is insured or self-insured. Ms. Wolf said she is confident that the data includes the landscape of insured and self-insured cases.

Ms. Wolf said regarding industry classes, health care workers accounted for the largest percentage of claims, followed by first responders.

Ms. Wolf said data shared by the states suggests that the majority of COVID-19 claims are fairly low cost and had minimal medical expenses. She said wage replacement benefits generally were limited to the quarantine or isolation period. Ms. Wolf said there is a small percentage of claims that were much more severe and higher in cost. She said there is a lot of speculation regarding the cost of the long-haul COVID-19 claims and what the cost of permanent partial awards might look like because COVID-19 can result in permanent damage to the lungs and to pulmonary function.

Ms. Wolf said that Texas received a lot of their data through a special data call and that the IAIABC was not able to obtain all of the information Texas collected. Therefore, not all information is available for Texas.

Ms. Wolf said there is one emerging issue for the state workers’ compensation administrations. She said as of December 2020, the IAIABC started receiving report of injury claims for people who have had adverse reactions to the COVID-19 vaccine, and they continue to receive them. Ms. Wolf believes this is contributing to the debate related to an employer’s ability to require vaccines, as well as to start discussion regarding the conditions that would make these claims compensable. She said there is activity at the state level that indicates these claims are more prevalent than initially seen.

A question was asked: “If a person is forced to miss work for quarantine and they submit a claim, are they denied for a negative test result?” Ms. Wolf said this is dependent upon the state and the insurer. She said the Washington State Department of Labor & Industries (L&I) made the decision to voluntarily pay for the isolation and quarantine period, even if the COVID-19 test result was negative, if there had been an exposure and the employer required a quarantine. Ms. Wolf said there is no broad rule to answer this question.

Mr. Stolyarov asked whether Ms. Wolf had any statistics regarding the denial for claims related to an adverse reaction from a COVID-19 vaccination. He said there could be certain influences on people submitting those claims that may lead the claims to be questionable from a scientific causation perspective. Ms. Wolf said she does not believe the data is in regarding adverse reactions from vaccinations yet and that states are just now receiving information regarding these claims. She said these claims would be reviewed in terms of their link to compensability. Ms. Wolf said that there was robust debate from the regulatory community about the compensability rules and that she believes each claim will be handled on a case-by-case basis. She said there was some discussion among some that would say if an employer made the COVID-19 vaccine mandatory as a part of an employment relationship and the individual has an adverse reaction, which results in medical treatment or time away from work, this would be a catalyst for filing a workers’ compensation claim.

3. **Heard a Presentation from the NCCI on Workers’ Compensation Presumptions and Loss Data**

Susan Donegan (National Council on Compensation Insurance—NCCI) said the NCCI has seen the workers’ compensation system demonstrate agility and resiliency over the past year. She said more than 20 states considered legislation to establish workers’ compensation presumptions regarding compensability for employees impacted by COVID-19. Ms. Donegan said nine states enacted legislation in 2020, while other states used the mechanisms of executive orders, emergency rules and bulletins. Most of these actions applied to first responders and health care providers, as well as other essential workers.

Ms. Donegan said the NCCI continues to see legislative and regulatory efforts continue in 2021. She said there are approximately 14 states that have various presumption bills pending and being introduced into legislatures. She said these bills have expanded or changed the presumption language to include things such as infectious diseases.

Ms. Donegan said in terms of rate and loss cost filings from 2020, the overall workers’ compensation system continues to experience unprecedented results. The calendar year combined ratios are expected to be quite favorable, coming in at 86%. Both premiums and losses are down for the 2020 calendar year in a similar magnitude. Premiums are -8.1 for private carriers, and she said it looks like final numbers will be closer to -10 with the NCCI’s latest data, which includes both private carrier and state funds.

Ms. Donegan said losses are at approximately a -0.6%, which includes a second-quarter anomaly with a big decline of about 16 to 20%. She said due to the lack of COVID-19 rate making data, the NCCI did not include an explicit adjustment for COVID-19 in the recent rate and loss cost filings. Ms. Donegan said the NCCI did not know whether COVID-19 would result in significant adverse loss development and loss rates, or whether the impact is going to be relatively small. She said that based
on early indications from reported data from the NCCI’s second-quarter medical data call, they saw two things. They looked at the medical transaction from the second quarter to get an idea of the medical component of COVID-19 losses, as well as any significant anomalies due to treatment of injured workers. The NCCI removed simple COVID-19 testing claims from the data.

Ms. Donegan said 20% of the COVID-19 medical includes an inpatient hospital stay. Of those requiring an inpatient hospital stay, one in five required intensive care unit (ICU) treatment. The average length of an inpatient hospital stay for COVID-19 claims ranged from 7.5 days to 11 days. If the ICU was involved, the hospital stay tended to be toward the higher end. Ms. Donegan said the cost of these claims averaged $38,000 for inpatient hospital stays and $60,000 for those stays requiring the ICU. She said there were more COVID-19 claims from females than males, and the average age for COVID-19 claims was 46. Ms. Donegan said 16% of the COVID-19 claims had signs of comorbidity treatments.

Ms. Donegan said there was little distortion in the time to treat injuries due to shutdowns or access to health care challenges, which is encouraging. She said the NCCI was not seeing any material change in the residual market composition at this time. Ms. Donegan said the residual market is made up mostly of small policies, where a substantial portion of the policies are for construction and a small percentage of policies include front-line workers.

Ms. Donegan said some of the topics arising during this year’s legislative sessions include legalization of marijuana, both medical and recreational, as well as CBD. She said there are currently numerous bills regarding these topics, as well as court cases about whether marijuana is covered under workers’ compensation laws.

Ms. Donegan said there are approximately 14 jurisdictions with pending legislation regarding single payer and universal health care. She said this legislation may or may not include workers’ compensation.

Ms. Donegan said there were 13 states that have introduced some form of independent contractor bill, as well as the federal rule. She said there has been nothing introduced in Congress regarding this issue. However, she said the NCCI has been hearing that there may be a bill regarding independent contractors that is similar to California’s independent contractor legislation that may be used as a model in Congress to address independent contractor issues.

Ms. Donegan said the NCCI is still considering COVID-19 as an extraordinary loss event and is working with several modeling firms to evaluate this exposure. She said one possibility would be to incorporate a pandemic load into existing catastrophe loads. Ms. Donegan said she wanted state insurance regulators to know the NCCI is looking at this exposure.

Ms. Donegan said almost 30 states have received filings regarding NCCI’s new Atlas manual modernization, and they have seen about 22 approvals. Some of the approvals are still pending. She said other states’ bills be rolled out later this year.

Ms. Donegan said the NCCI is looking at when and under what circumstances they will bring their staff back to the office and will begin traveling again.

Mr. Stolyarov asked if the NCCI would be offsetting the impact of work from home in future pandemic modeling. Ms. Donegan said that whether this is included in future modeling is something they will take into consideration. She said that one of the questions that has arisen is how working from home is affecting the class codes, at home injuries and safety. Ms. Donegan said the NCCI will follow this closely.

Ms. Donegan said the NCCI had some reclassification of class codes to cover COVID-19. However, she said the rates being discussed are last year’s rates, and class code presumptions were not pulled into last year’s rates; they reflected the prior year. She said this is being looked at for next year too, to see the shift in the reporting from carriers. Mr. McKenney said to the extent that teleworkers were reclassified to the appropriate class, he would have thought that everything was taken care of now. He said there was a class set up for teleworkers prior to COVID-19. Ms. Donegan said this was the case and that there was also one put in for COVID-19 for a deeper look.

Having no further business, the Workers’ Compensation (C) Task Force adjourned.
MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

Market Regulation and Consumer Affairs (D) Committee April 13, 2021, Minutes.................................................................9-2
Market Conduct Annual Statement (MCAS) Best Practices Guide (Attachment One)..............................................................9-7
NAIC Market Regulation Handbook (Attachment Two) ........................................................................................................9-21
Market Analysis Procedures (D) Working Group March 19, 2021, Minutes (Attachment Three)........................................9-33
Market Conduct Annual Statement Blanks (D) Working Group March 23, 2021, Minutes (Attachment Four)................9-42
Privacy Protections (D) Working Group March 29, 2021, Minutes (Attachment Six).................................................................9-51
The Market Regulation and Consumer Affairs (D) Committee met April 13, 2021. The following Committee members participated: Barbara D. Richardson, Chair (NV); Sharon P. Clark, Vice Chair (KY); Alan McClain (AR); Evan G. Daniels represented by Maria Ailor (AZ); Trinidad Navarro (DE); John F. King (GA); Dana Popish Severinghaus (IL); Chlora Lindley-Myers represented by Cynthia Amann (MO); Troy Downing (MT); Jon Godfread (ND); Chris Nicolopoulos represented by Edwin Pugsley (NH); Carter Lawrence represented by David Combs (TN); Jonathan T. Pike (UT); and Michael S. Pieciak represented by Kevin Gaffney (VT). Also participating were: Russell Toal (NM); Jessica K. Altman (PA); Larry D. Deiter (SD); John Haworth (WA); and Rebecca Rebholz (WI).

1. **Adopted its 2020 Fall National Meeting Minutes**

Commissioner Clark made a motion, seconded by Commissioner Godfread, to adopt the Committee’s Dec. 8, 2020, minutes (see NAIC Proceedings – Fall 2020, Market Regulation and Consumer Affairs (D) Committee). The motion passed unanimously.

2. **Heard a Presentation on the Activity of Lead Generators in Health Insurance**

Commissioner Navarro said for the past several months, state insurance regulators and officials from federal agencies have met to discuss improper marketing of health plans by various entities. He said prior to this ad hoc group, state insurance regulators in the health, market conduct and fraud areas were investigating these concerns, but not communicating with each other. He said after talking with the NAIC and other state insurance regulators, the states formed an ad hoc group designed to do two things. First, the ad hoc group was created to bring members of the Health Insurance and Managed Care (B) Committee and the Market Regulation and Consumer Affairs (D) Committee together to share information regarding entities that were improperly marketing health insurance products, including the use of lead generators, unsolicited phone calls, internet solicitations, and other marketing methods occurring in each state. Commissioner Navarro said these discussions have identified common practices, themes and actors. He said the group invited members of the federal government to participate, including the Center for Consumer Information and Insurance Oversight (CCIIO), the U.S. Department of Labor (DOL), and the Federal Trade Commission (FTC). He said as a result of those discussions, schemes have been identified and administrative actions taken. Second, he said the ad hoc group identified a need to look at and perhaps update or create new model laws to address the aggressive and improper marketing of health plans and the oversight of lead generators. He said the ad hoc group agreed that lead generators, whether by mailers, phone calls or internet solicitations, were part of the insurance sales process, but some states were concerned whether they had jurisdiction over these entities. However, he said all states agreed that there needs to be some oversight. He said the NAIC white paper, *The Marketing of Insurance Over the Internet*, needs to be updated to reflect the changes in how the internet is used today and how some entities use the internet to market plans in ways not contemplated only a few years ago.

Commissioner Navarro said the Antifraud (D) Task Force will be considering a proposal to formalize the ad hoc group into a working group under the Task Force. He said the working group would address two goals. First, it would facilitate continued discussions of state and federal insurance regulators about the improper marketing of health plans. Commissioner Navarro said participation of interested state insurance regulators would encompass state insurance regulators from all areas of expertise, including, but not limited to, health, market conduct, antifraud and legal. He said the working group would meet in regulator-only sessions to continue these ongoing discussions and potential prosecutions. Second, he said the working group would be charged with either modifying existing model laws or creating a model law: to 1) address the usage of lead generators in the sale of insurance products; and 2) update marketing rules to modernize the regulation of those activities.

Superintendent Toal commended the work of Commissioner Navarro and his staff. Superintendent Toal noted that this is a critical problem. There are many misleading and unapproved products being marketed. Additionally, contacting a lead generator can generate hundreds of calls to an individual consumer. Superintendent Toal said he would support the efforts in any way he can. Commissioner Altman said this is a very troubling issue. She noted that after the passage of the federal American Rescue Plan Act of 2021 (ARPA), she received calls soliciting Bidencare products. She said the biggest challenge is with unregulated entities. She said the state insurance regulators need to hold regulated entities responsible for the actions of unregulated entities that market their plans improperly. She said she is unsure if state laws allow that. Katie Keith (Out2Enroll)
and Harold M. Ting (Healthcare Consumer Advocate) noted that the consumer representatives support the work and are willing to assist.

3. **Adopted its Task Force and Working Group Reports**

Commissioner Richardson said Damion Hughes (CO) will be the new chair of the Market Conduct Examination Guidelines (D) Working Group. She said the Working Group summary report is in the materials. She also noted that the Market Actions (D) Working Group and the Advisory Organization Examination Oversight (D) Working Group met in regulator-only session due to the nature of their discussions focusing on specific company practices. She said there are no written or verbal reports for these working groups.

a. **Antifraud (D) Task Force**

Commissioner Navarro said the Antifraud (D) Task Force met March 24 and adopted its Nov. 16, 2020, minutes.

Commissioner Navarro said the Task Force received an update from the Antifraud Education Enhancement (D) Working Group. He said the Working Group hosted a webinar on Feb. 11 by CARCO regarding the mobile capabilities it can provide to state departments of insurance (DOIs) to assist in fighting insurance fraud. He said the Working Group will host the NAIC Investigator Safety training on June 2.

Commissioner Navarro said the Task Force received an update from the Antifraud Technology (D) Working Group. He said by finalizing the revisions to the *Antifraud Plan Guideline (#1690)*, the Working Group completed the first step in its charge to “review and provide recommendations for the development of an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions.” He said the Working Group will begin drafting a template for industry to use when creating their antifraud plan.

Commissioner Navarro said the Task Force discussed its 2021 charges and its continued monitoring of insurance fraud related to the COVID-19 pandemic. He said the Task Force will continue to monitor potential trends generated by the pandemic and hold meetings, as necessary, to bring general awareness at the state, industry and consumer levels.

Commissioner Navarro said the Task Force received an update on the NAIC Online Fraud Reporting System (OFRS) redesign. He said beta testing is scheduled to begin in April.

Commissioner Navarro said the Task Force received reports on matters of national interest to insurance fraud bureaus from the National Insurance Crime Bureau (NICB) and the Coalition Against Insurance Fraud (CAIF).

b. **Market Information Systems (D) Task Force**

Commissioner Kreidler said the Market Information Systems (D) Task Force met March 22 and reviewed its 2021 charges. He said the charge to “develop recommendations for the incorporation of artificial intelligence (AI) abilities in NAIC Market Information Systems for use in market analysis” was delegated to the Market Information System Research and Development (D) Working Group. This was done because the Working Group has members with expertise in this field, and it meets more frequently than the Task Force. Commissioner Kreidler noted that the Task Force remains responsible for the final product.

Commissioner Kreidler said the Task Force adopted the report of the Market Information System Research and Development (D) Working Group. He said the Working Group reported that it adopted a proposal for coding changes to the Regulatory Information Retrieval Systems (RIRS). He said the proposal will be posted to the Task Force web page and will be considered for adoption by the Task Force during the Summer National Meeting. He said the Working Group also adopted a change to the Uniform System Enhancement Request (USER) form process, which aligns the process to the agile approach used by the NAIC.

Commissioner Kreidler said the Task Force also adopted the Market Information Systems (MIS) Data Analysis Metrics and Recommendations.

Commissioner Kreidler said the Task Force reviewed outstanding USER forms.

b. **Producer Licensing (D) Task Force**

Director Deiter said the Producer Licensing (D) Task Force met on Mar. 26.
Director Deiter said during the meeting, the Task Force discussed state implementation of online examinations. He said 32 states have implemented online examinations, and three states are scheduled to implement online examinations by the end of April. Only three states decided not to implement remote online examinations. He said the Producer Licensing Uniformity (D) Working Group will be reviewing the examination standards in the NAIC State Licensing Handbook to ensure it is consistent with the state practices for implementing remote examinations.

Director Deiter said the Task Force heard a briefing on the National Association of Registered Agents and Brokers Reform Act of 2015 (NARAB Reform Act), which is a federal law that preempts state nonresident producer licensing laws and will establish nonresident producer licensing qualifications on a multi-state basis. He said the briefing addressed the impact on state producer licensing and included an overview of the NARAB Reform Act’s structure and governance and the responsibilities of the NARAB board. He said with the change in administration at the federal level, both the NAIC and the National Insurance Producer Registry (NIPR) leadership are monitoring federal activity that would lead to the appointment of the 13 member NARAB board and formation of NARAB.

Director Deiter said the Task Force received a report from the Producer Licensing Uniformity (D) Working Group. He said the Working Group continues to focus on licensing standards for pet insurance. He said the Task Force also received a report from the Uniform Education (D) Working Group. He said the Working Group continues to focus on state implementation of the 2019 Continuing Education Reciprocity (CER) Agreement, which 44 jurisdictions have signed.

Director Deiter said the Task Force received a report from the NIPR Board of Directors. He said the NIPR Board of Directors approved its 2021–2023 Strategic Plan. He said the plan has the following three pillars: 1) engaged and empowered teams; 2) customer-focused excellence; and 3) high-quality and reliable technology. He noted that NIPR also reported the release of a major upgrade to its Attachment Warehouse application. Finally, NIPR reported $47.9 million in revenue in 2020, a 5.7% increase from 2019.

Director Deiter said the Task Force discussed procedures for amending NAIC Uniform Producer Licensing Applications, and it will have a revised draft to address the comments submitted by state insurance regulators and interested parties.

Director Deiter said the Task Force received comments from the American Council of Life Insurers (ACLI) on how the NAIC’s initiatives on race and insurance relate to insurance producers and the desire to increase the number of minority producers. He said while not discussed by the Task Force, which met before the most recent meeting of the Special (EX) Committee on Race and Insurance, there have been three issues delegated to the Task Force from the Committee. He said the issues are: 1) the availability of producer licensing exams in foreign languages; 2) the steps exam vendors have taken to mitigate cultural bias; and 3) the number and location of producers by company compared to demographics in the same area.

d. Market Analysis Procedures (D) Working Group

Mr. Haworth said the Market Analysis Procedures (D) Working Group met Jan. 27, Feb. 25 and March 19.

Mr. Haworth said during these meetings, the Working Group adopted revisions to the Market Conduct Annual Statement (MCAS) Best Practices Guide (Best Practices Guide) (Attachment One). He said the Best Practices Guide had not been updated since its original adoption in 2014. He noted that among the revisions included identifying additional best practices, highlighting them in an appendix, and recommending a 14-day extension limitation. He said the Best Practices Guide is available on the Working Group’s web page.

Mr. Haworth said the Working Group also adopted revisions to the market analysis chapters of the NAIC Market Regulation Handbook (Handbook) (Attachment Two). He said considering the changing technology available to market analysts, the Working Group revised four chapters in the Handbook. He said the revisions will be forwarded to the Market Conduct Examination Guidelines (D) Working Group.

Mr. Haworth said the Working Group also adopted two changes affecting MCAS filings. First, the Working Group adopted a proposal to require companies to complete their attestations by line of business and by state. Second, the Working Group adopted a 14-calendar day limitation on extension requests from companies. He said companies will still be able to request additional extensions, if necessary, but for no longer than 14 days at a stretch.

Mr. Haworth said the Working Group continues its discussions on providing technical market analysis training to state insurance regulators, and it is receiving comments on what training is needed by jurisdictions.
e. Market Conduct Annual Statement Blanks (D) Working Group

Ms. Rebholz said the Market Conduct Annual Statement Blanks (D) Working Group met March 23.

Ms. Rebholz said the Working Group has four different subject matter expert (SME) groups currently working to finalize drafts for consideration by the Working Group. She said the SME groups are working on: 1) a new Other Health MCAS blank and data call and definitions; 2) a new Travel MCAS blank and data call and definitions; 3) new accelerated underwriting data elements and definitions for the Life MCAS blank; and 4) new digital claims data elements and definitions for the Private Passenger Auto and Homeowners MCAS blanks. She said the hope is to have these drafts exposed and considered by the Working Group prior to the June 1 deadline for updates to the MCAS for the 2022 data year.

Ms. Rebholz said the Working Group is discussing the placement of complaint and lawsuit data elements within the Homeowners and Private Passenger Auto MCAS blanks and reviewing the MCAS lawsuit definitions.

f. Privacy Protections (D) Working Group

Lois E. Alexander (NAIC) said the Privacy Protections (D) Working Group met March 29 and adopted its 2020 Fall National Meeting minutes, which included a discussion of the initial draft gap analysis of consumer issues.

Ms. Alexander said the Working Group received NAIC status reports on federal and state privacy legislation. She said the federal report indicated that the U.S. Congress (Congress) believes there is a need for federal data privacy legislation, but differences in approaches have thwarted efforts to enact comprehensive legislation. She said the points of contention include: 1) whether and to what extent federal legislation should preempt state laws; and 2) whether the legislation should include a private right of action. She said the NAIC continues to engage with Congress, oppose preemptive legislative proposals, and inform Congress of the Working Group’s efforts to update NAIC model laws. She said the NAIC continues to underscore the importance of not disregarding the existing state regulatory framework or inhibiting ongoing efforts in the states to develop laws and regulations in the best interest of consumers.

Ms. Alexander said the state report indicated that at least 30 states introduced data privacy legislation in 2020. She said many of them were comprehensive and similar to the California Consumer Privacy Act (CCPA). However, very few of them were enacted because the COVID-19 pandemic disrupted legislative sessions. Ms. Alexander said in 2021, bills have been introduced in 23 states that focus on business obligations stemming from consumer rights, but the bills vary in substance. She said many of the bills apply to for-profit businesses that: 1) have global annual gross revenues in excess of $23 million; 2) annually buy, sell or share the personal information of 50,000 or more consumers for commercial purposes; or 3) derive 50% or more of its global revenues from selling or sharing personal information. She said common issues have emerged, such as: 1) a requirement that covered entities perform a risk assessment; 2) providing for a private right of action; 3) addressing data security and privacy; 4) a resemblance to the General Data Protection Regulation (GDPR); and 5) exempting data collected in compliance with the Gramm-Leach-Bliley Act (GLBA), as well as entities subject to the GLBA. Other exemptions would only exclude the data collected in compliance with the GLBA, while still regulating the entity.

Ms. Alexander said the Working Group reviewed additional guidance through the Market Regulation and Consumer Affairs (D) Committee in the form of the NAIC member-adopted strategy for consumer data privacy protections. She said the strategy charges the Committee with: 1) summarizing consumer data privacy protections found in the Health Information Privacy Model Act (#55), the NAIC Insurance Information and Privacy Protection Model Act (#670), and the Privacy of Consumer Financial and Health Information Regulation (#672); and 2) identifying notice requirements of states, the European Union’s (EU’s) GDPR, and the CCPA and how insurers may be subject to these requirements. She said the Working Group has completed both charges.

Ms. Alexander said the strategy also charges the Committee with: 1) identifying corresponding consumer rights that attach to notice requirements, such as the right to opt out of data sharing, the right to correct or delete information, the right of data portability, and the right to restrict the use of data and how insurers may be subject to these requirements; 2) setting forth a policy statement on the minimum consumer data privacy protections that are appropriate for the business of insurance; and 3) delivering a report on the charges by the Fall National Meeting.

Ms. Alexander said the strategy additionally charges the Committee to: 1) engage with state attorneys general (AGs), Congress, and federal regulatory agencies on state and federal data privacy laws to minimize preemption provisions and maximize state insurance regulatory authority; and 2) reappoint the Working Group to revise NAIC models, as necessary, to incorporate
minimum consumer data privacy protections that are appropriate for the business of insurance. She said these last charges are also to be completed by the Fall National Meeting.

Ms. Alexander said the Working Group discussed comments concerning the gap analysis received after its Nov. 20, 2020, meeting. She said comments were received from ACLI, the Coalition of Health Carriers, the National Association of Mutual Insurance Companies (NAMIC), and the American Property Casualty Insurance Association (APCIA).

Ms. Alexander said the Working Group announced that a consumer privacy protections panel will speak at the virtual NAIC Insurance Summit in June.

Commissioner Richardson asked for a motion to adopt the reports of the Market Regulation and Consumer Affairs (D) Committee’s task forces and working groups, including the following action items: 1) the MIS data Analysis Metrics and Recommendations adopted by the Market Information Systems (D) Task Force; 2) revisions to the Best Practices Guide adopted by the Market Analysis Procedures (D) Working Group; 3) revisions to the four market analysis chapters of the Handbook adopted by the Market Analysis Procedures (D) Working Group; 4) the 14 calendar-day limitation on MCAS filing extension requests adopted by the Market Analysis Procedures (D) Working Group; and 5) the requirement for companies to identify MCAS filing attesters by both line of business and by state to be implemented for the 2021 data to be reported in 2022, which was adopted by the Market Analysis Procedures (D) Working Group.


4. Discussed Other Matters

Birny Birnbaum (Center for Economic Justice—CEJ) encouraged the Committee to become more engaged in the work of the Special (EX) Committee on Race and Insurance. He said the CEJ drafted a proposal for a comprehensive work plan to address systemic racism in insurance. Included within the proposal is the development of tools and resources for regulatory oversight. He said the development of the tools requires market regulation data collection that is sufficient to monitor consumer outcomes by prohibited class characteristics and the identification of gaps in regulatory skills and resources that are necessary for the analysis of disparate impact and proxy discrimination. He said both activities fall within the purview of the Market Regulation and Consumer Affairs (D) Committee.

Mr. Birnbaum said all aspects of insurance operations, such as marketing, claims and antifraud, are subject to racism and disparate impact. He said it is important for market regulators to be well represented in the work of the Special (EX) Committee on Race and Insurance.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.
MCAS BEST PRACTICES GUIDE

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Introduction

The Market Conduct Annual Statement (MCAS) was developed with the input of state insurance regulators and representatives from the insurance industry to provide an analysis tool for certain key market data elements. Some of the states collected private passenger auto data as early as the 1990s. In 2003, the NAIC Market Regulation and Consumer Affairs (D) Committee established an annual statement pilot program for life and annuity and property/casualty companies. Today, 49 the states participate in MCAS and the NAIC collects the data on behalf of the states.

By using common data and analysis, the states have a uniform method of comparing the performance of companies. If a company’s performance appears to fall outside of industry norms, the state will want to undertake further review of that company. The purpose of this document is to encourage the use of best practices in the collection and review of MCAS data.

Before moving forward with follow-up activity or continuum actions, the following three principles should be considered:

- Always refer back to the underlying raw data. Is the company following the definitions? Did they leave claims open when actually all payments had been made?
- Before moving on, check the company comments. These comments can save time by directing you to specific data or explaining a market shift.
- Always interpret the MCAS within the context of all other available information. Was there a catastrophic event that caused the spike in number of claims?

Data consists of various market indicators, primarily related to two areas:

- Claims handling – claim denials, processing times and lawsuit activity.
- Underwriting – new issues, policies in force, non-renewals and cancellations.

Other line-specific indicators are used to determine, for example, the number of policy exchanges and resisted claims for life insurance policies.

As of the document revision date, MCAS data are collected for the following lines of business with 49 participating jurisdictions:

- Annuity
- Disability Income
- Health
- Homeowners
- Lender-Placed Home and Auto
- Life
- Long-Term Care
- Private Passenger Auto
- Private Flood (effective for the 2020 data year).
MCAS Timeline

- September – Call letter review/update
- December 15 - Call letters sent
- January 31 – Portal closes for the prior year plus one data
- March – April – MCAS Training Webinars
- April – Companies submit data and make extension or waiver requests
- April 30 – Data submissions are due*
- April – June – Data Validation by the NAIC and states
- May – June – data analysis by states and next steps
- May – States contact late filers
- July 1 – Scorecards are published

Please note that some lines of business may have due dates that vary from the standard April 30 filing due date. For the most current information on due dates for all lines of business, please refer to the MCAS webpage's calendar of key MCAS dates (http://www.naic.org/mcas_main.htm).

September: Call Letter Review/Update

In September, the NAIC requests that the participating states’ MCAS contacts submit any changes to the data call letters. These letters are sent to companies to obtain information for the next year. The data call letter identifies changes to the MCAS submission, as well as the contact person for the state requesting submission.

★★ Best Practice: Be sure your MCAS contact is current. You can check/update your state MCAS contact here: Link to Participating Jurisdiction Contacts.

Mid-December: Call Letters Sent

In December, the data call letters are sent to each company’s MCAS contact; companies are expected to keep their contact information current. At the same time, the NAIC updates its submission portal in preparation for the submission of new data.

January 31: Portal Closes

By January 31, companies may no longer use the MCAS portal to make changes to the prior year’s data. Changes to prior year’s data will need prior approval from the state(s) affected.

March to April: Training Webinars

The NAIC provides webinars detailing changes to the MCAS data process. Additional information is also available on the NAIC website. To properly analyze the MCAS data, the analyst needs to stay current on what the ratios and data elements mean and why these elements were chosen.

For companies not familiar with the MCAS process, the NAIC provides training on how to submit filings.

The MCAS webpage (http://www.naic.org/mcas_main.htm) has the most current training materials for each filing year on the left side of the page under the heading “TRAINING”. NAIC Education and Training (https://content.naic.org/education_schedule.htm) also provides links to training for both MCAS and market analysis (Market Analysis Techniques (MAT) On-line).
April: Companies Submit Data and Make Extension or Waiver Requests

Several methods are used to address questions by the companies regarding data submissions, including bulletin boards, frequently asked questions (FAQs), training webinars and other resources. The NAIC maintains a webpage dedicated to explaining the MCAS process and any changes expected. These resources are available to assist the states with incoming questions from insurance companies.

MCAS resources are located along the left-hand side on the MCAS webpage (http://www.naic.org/mcas_main.htm).

April 30: Data Submissions Due

Late Filings and Revised Filings

Late or inaccurate filings may impact statewide ratios. Regulators should balance the need for accurate data with company accountability. Companies should be encouraged to file timely and accurately. Changes associated with re-filings are detailed in the “MCAS Audit Trail” report, as are any comments the company may have as to why the data was changed. Companies that submit data late, or with changes, may have internal control issues. It also needs to be determined if a company is re-filing for a small number of states or is re-filing globally.

**Best Practice:** When a company re-files to correct an issue, the analyst should review the filings submitted to other states. If filings in other states have the same issues, then coordination with other states, or the domestic state, should be initiated when contacting the company.

Company re-filings should be kept to a minimum. A significant volume of re-filings can alter overall state ratios and change company rankings. Regulators should develop strategies to ensure data is submitted correctly the first time. Companies that habitually re-file over several years should be identified and contacted to help remediate difficulties. Companies should submit an extension request rather than submit data known to be incorrect with the expectation that it can simply re-file at a later date. If a company does have to re-file, it should provide a complete explanation, in the comments section, of the data errors and steps taken to ensure there is not recurrence.

If an insurer that files in multiple states has more than two filings in error within a five-year period and/or files late (a late filing includes failing to meet an extension due date in two consecutive years), information is available on i-Site+ in a Tableau dashboard available to regulators. If a majority of jurisdictions agree, a referral will be made to include the company in the Market Actions (D) Working Group’s National Analysis Program. To ensure that companies are aware of the submission requirements, the NAIC develops training classes for company as well as state representatives.

Companies who have multiple revised filings must provide a risk management or loss control policy that outlines their process to address these control/compliance issues. Companies that have a pattern of submitting late or re-filing may have other internal control issues that require additional analysis.

**Best Practice:** Companies that habitually re-file over several years should be identified using the Tableau dashboard and contacted to help remediate difficulties.

Waiver and Extension Requests

**Waivers:** Data call letters are sent to each company that exceeds premium thresholds on the financial annual statement (FAS) for each line of business captured by MCAS. Because there are slight definitional discrepancies between the FAS and MCAS, a company may receive a call letter even though they are exempt from filing. For example, antique auto products may be reported in the FAS as private passenger auto business, while such products are excluded from the MCAS. In these situations, the company may request a waiver from each state in which it markets these products.
Please Note: Companies that market regular private passenger auto products and reach the $50,000 threshold are still required to file even if they also market custom auto products.

It is recommended that the states verify the company’s request prior to granting a waiver.

For example, there may be situations where the company requests a waiver for a product line that is actually covered under MCAS. This happened in the past when companies stated they only market motorcycle coverages. While there was a time when motorcycle coverages were excluded from MCAS, this was changed for the 2011 submission. As some companies were not aware of the change, waivers were requested.

Extensions: There are situations where the company knows it will not be able to submit its MCAS filing on a timely basis. In these situations, the company may request an extension of up to 14 calendar days. Requests should be accompanied by the following:

1. Have you requested an extension within the five previous years?
2. If so, is your current request for the same reason?
   a. If the answer is yes, please provide the following:
      i. Any steps your company has taken to prevent this concern moving forward.
      ii. The progress your company has made toward streamlining MCAS filings so it is not dependent on staffing concerns.
      iii. Whether your company includes this process/review as part of the risk management plan.
3. If a company asks for an extension on or after the due date, additional information must be required of the company.

   ★ Best Practice: Requests for additional information should be made within the MCAS Extension tool. This allows your jurisdiction and other jurisdictions to view the requests over multiple years.

All extension requests must be processed through i-Site+. If a company’s request is not processed in i-Site+, the state analyst will not be able to see if the company has actually filed when reviewing the MCAS Filing Status Report. Analysts should review the responses of other states to the extension request. Coordination among the states is important to maintain consistency. Otherwise, one state may grant a 14-day extension where another might not grant one at all.

For additional reference, please see the MCAS Industry User Guide located in the Resources section of the MCAS webpage (http://www.naic.org/mcas_main.htm). For situations where a company requests more than a two-week extension, it is recommended that such an extension request be coordinated with other MCAS states.

April to June: Validation of Incoming Data

It is important to review the MCAS Correspondence Tracking link in the Summary Reports Section of i-Site+ when beginning review of a company. The NAIC notifies reporting companies by email if data anomalies are discovered.

In addition, inferences should be based only on statistically credible data. If the company is small and has few claims, a delay in a small number of claims could create a large impact on various ratios. The company should also be aware that its data is outside the norm and provide comments. If the company has made comments, the analyst should review them by going to the MCAS Pick-A-Page Section in i-Site+ and select the Jurat Company Contact Information report, as well as the interrogatories.
MCAS Data Review

Tier 1: Validation Review

- Once a company has submitted its MCAS data, the NAIC performs validations to test the data for internal consistency and reasonability. For example, a validation exception is generated if a company’s direct written premiums reported on their FAS and those reported on the MCAS vary by +/- 20%. All validation warnings can be viewed on the company’s Validation Exception Report, which is available on i-Site+. These tolerances have been established to avoid corresponding with insurers regarding validations that are generated due to small amounts of data provided by the company or small (immaterial) differences.

- The following table provides some examples of MCAS data validation conducted by the NAIC:

<table>
<thead>
<tr>
<th>Line Business of</th>
<th>Validation Description</th>
<th>Review Tolerance</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPA/HO claims closed w/o pay &gt; claims closed with pay</td>
<td>(claims closed with pay + claims closed w/o pay) &gt;= 100 claims AND &gt;= 25% more claims closed w/o pay than with pay</td>
<td></td>
</tr>
<tr>
<td>PPA/HO policies in force &lt; new policies issued</td>
<td>policies in force and policies issued each must be &gt;= 500 AND policies in force is three times &lt; new policies issued</td>
<td></td>
</tr>
<tr>
<td>HO FAS direct written premiums (DWP) and MCAS DWP vary by +/- 20%</td>
<td>MCAS &gt; FAS by &gt;= 100% OR FAS &gt; MCAS by &gt; = 20%</td>
<td></td>
</tr>
<tr>
<td>Life/Annuity total claims closed with payment &lt;= claims denied, resisted or compromised</td>
<td>(total claims closed with payment) + (claims denied, resisted or compromised) &gt;= 100</td>
<td></td>
</tr>
<tr>
<td>Life/Annuity replacements applied for &lt; policies issued</td>
<td>(replacements applied for + policies issued) &gt;=100 AND &gt;= 25% more replacements applied for than policies issued</td>
<td></td>
</tr>
<tr>
<td>Life/Annuity new policies issued or policies in force &gt;0 then DWP must be &gt; 0</td>
<td>(new policies issued &gt;50) OR (policies in force &gt; 100) AND DWP = 0</td>
<td></td>
</tr>
<tr>
<td>Life/Annuity DWP &gt; 0 then (policies issued + policies in force) must be &gt; 0</td>
<td>DWP &gt; 100,000 AND Policies in force = 0</td>
<td></td>
</tr>
</tbody>
</table>

Tier 2: Ratio and Indicator Review

- The MCAS published ratios are also reviewed to find any company ratios generated from data entry errors or other data anomalies. The ratio results for a given state are reviewed by sorting them to find extreme high or low values. The data is then further examined to determine if a possible data error exists.

- In addition to the MCAS published ratios, additional ratios and indicators are examined to find potential data errors. Following are examples of additional ratios and indicators that are used by NAIC staff:

| PPA/HO Dwellings or autos to policies in force |
| PPA/HO DWP to policies in force |
| PPA/HO Claims opened to policies in force |
| PPA/HO Suits open during the period to policies in force |
| PPA/HO Suits open end of period to (claims/1000) |
| PPA/HO Median days as reported compared to calculated median days |
| LIFE Denied, resisted or compromised claims to policies in force |
| LIFE/ANNUITY Surrenders to policies in force |
| LIFE/ANNUITY DWP to policies in force |
| LIFE Face amount of policies in force to policies in force |
Tier 3: Individual Data Element Review

- Once the previous two tiers of review have been completed, each individual data element, by line of business and state, are reviewed. This review is done to find possible data errors. Where possible, the data elements are compared to the value reported in the previous year to identify significant changes in reporting.

Validation of MCAS filings are performed by NAIC staff as well as the participating jurisdictions. All inquiries sent by the NAIC data analysts to companies are located in the Correspondence Tracking application found in i-Site+. Within Correspondence Tracking, an analyst can review the correspondence between the NAIC and the company, and can see the status of the validation issue—"in progress", "state handling", "resolved", or "no action required".

**Best Practice:** It is the responsibility of the states to verify that the data is reasonable. For example, are ratios that are extreme outliers an accurate reflection of company market practices, or are they reporting errors? Before contacting the company, check to see if the company has already been contacted by an NAIC data analyst for the same issue.

May to June: Analysis

For specifics on ratio formulas, see the MCAS Scorecard Ratio Formulas on the MCAS webpage (http://www.naic.org/mcas_main.htm).

The core of any MCAS analysis consists of developing ratios that serve as potential indicators of company performance and comparing these ratios to an industry-wide baseline. To assess the degree to which ratios deviate from the baseline, analysis can be done in various ways. One of the easiest is to use the MCAS Market Analysis Prioritization Tool (MAPT) for the respective line of business and determine the average for each ratio. Then, identify companies with ratios substantially above that average. For example, private passenger auto Ratio 3 is the percentage of claims paid beyond 60 days. If the state average for all private passenger auto companies is 25%, then companies with a value of 50% could be considered outliers. Though there may be situations where the focus is on very high ratios, attention should be paid to low ratios, as well. A company with a very low ratio of 5% for Ratio 3 may not be conducting any investigations and simply paying all claims. This could have a future impact for the company if loss ratios suddenly increase.

**Ranks**

The company’s ratio rank is a function of the company’s ratio value compared to those of all other filing companies. A ranking of zero indicates the ratio value is zero, null or incalculable. A ranking of 21 indicates the ratio value is greater than 100 or the ratio has the highest value of those being ranked. This may be due to anomalies with the data. It should be noted that private passenger auto and homeowners underwriting ratios cannot be calculated at the coverage level, as underwriting information is collected only at the line of business level.

In addition to the overall ranks, the homeowners and private passenger auto lines of business have a claims rank, an underwriting rank, and a suits rank. These supplemental ranks are calculated at the line of business, state and national levels. Ranks can be used to look at multiple companies simultaneously. Outliers can be identified by finding the mean and then calculating the standard deviation in Microsoft Excel or other spreadsheet programs.
Ranks should be evaluated with an understanding of the data elements and underlying raw data. There may be variations in the raw data that make a company appear normal when looking at the ranking. Also, companies with low ranks may be cause for concern. Very low ranks may indicate problems with the company’s data. Analysts should not concentrate only on those companies with higher ranks. On occasion, carriers with low underwriting ranks have failed to report certain underwriting activity; e.g., non-renewals or cancellations. Also note that ranks can be trended; i.e., companies moving up or down in ranks over a three-year period can be identified.

It is important to determine whether the underlying data is statistically credible. Due to what statisticians term the “law of large numbers,” valid inferences require a sufficient volume of data points. Ratios for smaller companies may not be meaningful indicators of general business practices but, rather, random fluctuations in the underlying data.

For example, if a company has only three claims and two of them were denied, their ratio of denials is 60%, and is very likely well above the industry norm. However, any inferences based on this ratio are likely to be unwarranted.

**Tools and Reports Available**

When reviewing MCAS filings, the analyst may find it useful to review rate and form filings to see what business is being marketed. The company’s Management’s Discussion and Analysis (MDA) filing may also assist. The MCAS-MAPT is a great tool to conduct analysis, as additional worksheets can be added for doing sorts or conditional formatting, and columns that are not needed can be hidden.

Review of the interrogatories is also helpful. Companies are to report if they are still actively writing; if there has been a significant event or business strategy change that affects the data; or if the insurer has sold, closed, or moved a block of business to another company. Having this knowledge is extremely helpful when reviewing the company’s data, especially when comparing it to prior years.

i-Site+ shows premium changes per year, which may be of assistance, and Microsoft Access can also be used to query several MAPT reports at the same time.

**Best Practice:** Make use of the tools available for MCAS analysis including; rate & form filing history, the company’s MDA, the MCAS-MAPT and a review of interrogatory responses.

**Analysis Techniques**

Analysis is an ongoing process, but it should begin as soon as data becomes available. The MCAS-MAPT can be used to review rankings and ratios. The mean of the data can be identified, and data that significantly deviate from the mean can be viewed as outliers. In other situations, depending on the skew of the data, using the median may be more representative of the center point of the data. Whether to use the mean or the median should be based on the analyst’s judgment, based upon a particular data set.

Thresholds can also be established in Tableau or using Microsoft Excel. With Microsoft Excel, conditional formatting can be used to quickly identify outliers. The analyst may also use highlighted colors with conditional formatting.

**Trending**

The MCAS-MAPT provides the availability to trend data. Companies that ranked low in prior years but high in the current year can be quickly identified. Claims payment patterns can also be trended to see if there are any patterns of concern. If a company is just entering a product line, trending can be used to identify the new activity and the company’s growth. If a company is leaving a market or
shifting product lines, these activities can also be monitored.

Data needs to be monitored to identify false trends or reporting errors. If the company recently expanded into the state but trending indicates a decline, then additional steps to verify the data must take place. This may require contacting the company or performing market analysis.

Comparisons

Once the data is in a searchable format, such as in Tableau, Excel or Access, additional comparisons can be performed. The data can be viewed by insurer group to identify possible non-standard underwriting companies or outlying companies that are part of the group.

Company to Company

Comparisons to other companies can also be conducted. If the industry is seeing higher claims utilization, is that reflected in the data? Are some companies affected more than others?

Newer companies may behave differently than older ones or may have slightly different policyholder demographics.

Standard versus Non-standard Lines

It is important for the analyst to be familiar with the company being reviewed. There may be value to looking at the rate or form filings to determine if products offered are standard or non-standard. Some companies that offer non-standard lines, such as homeowners or private passenger auto, may rank higher on many ratios than standard or preferred coverage. By understanding the product design before review, the analyst can determine if the non-standard company should be reviewed separately from the other companies. When reviewing private passenger or homeowners’ coverages, it is important to look at the interrogatory page that contains information about the amount of business written in the non-standard market. This can be located in the MCAS Pick-A-Page section of i-Site+. It can also be found on MCAS-MAPT.

For example, non-standard companies’ ratios generated from claims data may deviate from the industry norm because, historically, more claims are filed by non-standard policy owners or insureds are harder to locate.

Company to State Ratio

The company can be viewed in relation to the state-wide ratios. Is the company significantly higher or lower than average compared to other companies? Does a particular ratio appear to be high for a company compared to the state ratio? Is the company still writing in the line of business? Are there any trends over the past several years? These questions need to be considered when looking at company data compared to state ratios.

State Ratios to Other State Ratios

Average ratios or company ratios may differ between the states. If the company is writing the same product in specific states, MCAS data in those states may be relevant. The company may have different claims adjusters in different states. Also, data that should be similar between the states may be vastly different.

The analyst may review neighboring states for comparisons of state ratios or may look for states that have similar premium volumes and demographics. This approach may identify if the company has similar issues in multiple states and allow the analyst to develop strategies to resolve them.
Review of Individual Company Data

The underlying data must always be considered. If a company has very few claims and reports a delay in only one, this might cause the rankings and ratios to spike significantly. Annuity companies that no longer write business may see Ratio 3 spike when a consumer surrenders a policy.

It is important to note that the ratios are based on the underlying data. If the underlying data has inconsistencies, it may not be noticed by looking at the overall ratios.

As stated previously, the analyst needs to know and understand the various companies’ markets and how business is conducted in the state. If ratios are outliers, the analyst should look at the underlying data to see if the ratios are skewed for certain types of claims.

For example, for private passenger auto claims, the analyst should look at how claims are processed for collision, bodily injury, etc.

Also be careful of “false positives.”

For example, Ratio 3 for life and annuities measures surrenders to new policies issued. If the company writes little or no new business, but has surrenders, this ratio may be very high. Again, it is important to know what the company writes in the respective state. Where applicable, this can be determined by reviewing filings submitted to the state for review. The company may also use its comments section to provide clarification of outliers.

Combining MCAS with Other Market Information Tools

Analysis should not focus exclusively on MCAS data to make inferences about a company’s market behavior. Data from other NAIC systems—such as the Regulatory Information Retrieval System (RIRS), Market Analysis Review System (MARS), Examination Tracking System (ETS) and Market Analysis Prioritization Tool (MAPT)—provide a basis for a much more general overview of a company’s market performance. The data may be viewed in conjunction with the MAP-T by a specific line of business; e.g., private passenger, homeowners, life, etc. The state insurance department’s complaint database can be a resource, as well. By the time MCAS data is received, there may be five or six months of complaint data available within the department not viewable from the i-Site+ Level 1 screens. In addition, other states may have already performed Level 1 or other analyses, and such actions can be viewed in i-Site+. Just because the MCAS filing is unremarkable and does not reveal any areas of concern, the analyst should not infer that the company does not have other issues.

For example, the company could still be marketing unapproved forms through unlicensed producers, or engaging in other behaviors not reflected in the MCAS ratios.

Best Practice: Analysis should not focus exclusively on MCAS data – when there are questions, bring in data from other NAIC systems to gain a fuller understanding of a company’s market behavior.

Next Steps

When to Contact the Company

If MCAS data anomalies have no apparent explanation, then the analyst should contact the company’s MCAS representative. Every effort should be made to determine whether the data is accurate, and whether the representative can provide an explanation for the anomalies related to a company’s market practices. If the company representative appears to lack training or the understanding to adequately address concerns, then additional analysis of the company may be
appropriate.

For example, does a high ratio of claims closed without payment reflect the manner in which claims are counted in the production of the MCAS, as opposed to claims handling practices?

**Integrating MCAS Data into the Market Analysis Framework**

Level 1 analysis incorporates MCAS data for all MCAS lines in the states that require MCAS submissions. It is important to note, however, that there are states that do not require MCAS submissions; in these cases, MCAS data will not be incorporated into Level 1 or Level 2 analysis.

As noted in this document, there may be a variety of reasons a company is an outlier that are unrelated to market practices; in these cases, a Level 1 and/or Level 2 analysis may be revealing.

The analyst may also want to review Level 1 and Level 2 analyses conducted by other states prior to contacting the company about issues or concerns. This will allow the analyst to detect possible data issues, as opposed to contacting the company on a range of issues that may not represent true concerns. There may be other times when the company should be contacted directly.

For example, a significant number of lawsuits may require contact with the company for clarification.

**Integrating Other Data into MCAS**

The intent of market analysis is to understand how companies interact with consumers. Are claims paid timely and correctly? Are the products appropriately marketed for the consumer? If the analyst has an understanding of the products filed and approved, the type of producer marketing the product and the company’s claim payment method(s), the analyst will be better able to put the company’s MCAS submission into context. If the MCAS data suggests a change in the company’s practices, then the analyst can be more proactive in protecting consumers.

**July 1: Scorecards**

MCAS scorecards are produced each year to show the jurisdiction-wide ratio and the distribution of ratios for all companies filing an MCAS in a given jurisdiction. Individual company ratio information is available through the online MCAS application. A company can gain a better understanding of where they fit in the insurance marketplace and what opportunities may exist to improve their performance in a jurisdiction by comparing their jurisdiction-specific ratios to the scorecard for that jurisdiction. Each year, the most recent scorecards for all participating MCAS jurisdictions are made available on the NAIC MCAS Web page via a link to the Contacts and Scorecards ([https://content.naic.org/mcas_data_dashboard.htm](https://content.naic.org/mcas_data_dashboard.htm)).

Scorecards are posted on the MCAS Web page. The scorecard allows companies to compare their specific results to the rest of industry for the particular line of business. Please refer to [https://www.naic.org/mcas_main.htm](https://www.naic.org/mcas_main.htm) for key dates.
Appendix A: MCAS Best Practices

**Best Practice:** Be sure your MCAS contact is current. You can check/update your state MCAS contact here: Link to Participating Jurisdiction Contacts.

**Best Practice:** When a company re-files to correct an issue, the analyst should review the filings submitted to other states. If filings in other states have the same issues, then coordination with other states, or the domestic state, should be initiated when contacting the company.

**Best Practice:** Companies that habitually re-file over several years should be identified on the Tableau dashboard and contacted to help remediate difficulties.

**Best Practice:** Requests for additional information should be made within the MCAS Extension tool. This allows your jurisdiction and other jurisdictions to view the requests over multiple years.

**Best Practice:** It is the responsibility of the states to verify that the data is reasonable. For example, are ratios that are found to be extreme outliers an accurate reflection of company market practices, or are they reporting errors? Before contacting the company, check to see if the company has already been contacted by an NAIC data analyst for the same issue.

**Best Practice:** Make use of the tools available for MCAS analysis including; rate & form filing history, the company’s MDA, the MCAS-MAPT and a review of interrogatory responses.

**Best Practice:** Analysis should not focus exclusively on MCAS data – when there are questions, bring in data from other NAIC systems to gain a fuller understanding of a company’s market behavior.

- Be sure your state’s MCAS contact is current – check here: https://www.naic.org/mcas_data_dashboard.htm

**Analysis:**

- Always refer back to the underlying raw data
- Review ratio formulas to understand what each ratio is measuring https://www.naic.org/mcas_main.htm found under Resources > Scorecard Ratio Formulas (PDF)
- Check interrogatory pages for comments that may explain outliers
- Verify that reported data is reasonable; determine if outliers result from accurate data or are reporting errors
- Determine whether the underlying data is statistically credible
- Compare company data trend to state ratio trend
- Use other Market Information Tools to analyze company behavior in addition to MCAS and MAPT
- Contact the company if data anomalies have no apparent explanation

**Waiver/Extension Requests and Late Filings:**

- Check company’s history of waiver/extension requests
- Verify that company is entitled to a waiver before granting one
- Review filings submitted to other states to determine if similar issues are present
- Any company filing in multiple jurisdictions with prior history of extension requests, late filings, or incorrect filings will be elevated to discussion in the Market Analysis Bulletin Board.
Appendix B: Resource List

For Industry:

NAIC website
www.naic.org

Industry Links with a link to MCAS page:
https://content.naic.org/index_industry.htm

MCAS History, General Filing Information, Training, Resources
http://www.naic.org/mcas_main.htm

The MCAS webpage is data year specific. Along the top of the webpage, underneath the logo, you will see four data years to choose from—the next year, the current year and the two prior years. The resources available on the MCAS Webpage often change from one year to the next as revisions or additions are included for the new year. Be sure you choose the relevant data year before choosing the resource. Descriptions of each resource is included in the main page narrative.

The resources on the MCAS Webpage include:

- The Participation Requirements
- Training materials for companies
- The data collection worksheets (blanks) for each line of business
- The Data Call and Definitions for each line of business
- A summary of changes for each data year
- The MCAS User Guide for each year (includes instructions for companies and a listing of all validations)
- CSV upload instructions and templates for each line of business
- Scorecard ratio formulas
- Data Call Communications—Call letter, authority references, and participating jurisdiction signatures
- FAQ—An FAQ for all lines of business is available near the “log in” button used by companies
- Key Dates—The MCAS Webpage also contains key dates for the data year filings. The key dates include the date of the call letter, training dates, filing due dates, scorecard dates and the last date filings for the prior data year can be submitted.

MCAS Scorecards:
https://www.naic.org/mcas_data_dashboard.htm

Market Analysis Procedures Working Group Webpage

The Market Analysis Procedures Working Group (MAP) is responsible choosing which lines of business to include in MCAS and revisions to current data. On its page you can find current comments on information on lines of business under consideration.

Also on the MAP website, under Related Documents, there are links to:

- Process for Selecting New Lines of Business
- MCAS Revision Process
- The MCAS Best Practices Guide

Market Conduct Annual Statement Blanks Working Group Webpage

The Market Conduct Annual Statement Blanks Working Groups (MCAS Blanks WG) is responsible for the creation of new line of blanks, and the review and revisions of current MCAS blanks. On the MCAS Blanks WG website you will find discussions and comments on the creation of new blanks and reviews of existing blanks.
Under the Related Documents section there are links to:

- Data Calls and Definitions of recently adopted lines of business that will be collected in a later data year.
- **MCAS Revision Process**
- Recently adopted revisions and clarifications of current lines of business

**For Regulators:**

MCAS History, General Filing Information, Training, Resources

[http://www.naic.org/mcas_main.htm](http://www.naic.org/mcas_main.htm)

MCAS Scorecards:

[https://www.naic.org/mcas_data_dashboard.htm](https://www.naic.org/mcas_data_dashboard.htm)

NAIC i-Site+ Summary Reports:
- MCAS Correspondence Tracking
- MCAS Filing Status Report
- MCAS-MAPT
- MCAS Ratio Summary Report
- MCAS State Ratio Distribution Report
- MCAS Validation Exception Summary

NAIC i-Site+ Company Reports:
Enter **Cocode** of Company
Go to **Company/Firm Reports**

Under **Market Conduct Annual Statement**, the following reports are available:
- MCAS Audit Trail
- MCAS Company Specific Report
- MCAS Company Waiver and Extension Report
- MCAS Line Reports
- MCAS Pick a Page
- MCAS Validation Exceptions
Chapter 6—Basic Analytical Tools

A. Market Conduct Indicators and Priorities

The common denominator of this handbook is change. When there are changes in laws or regulations or in the marketplace, they affect processes and procedures within insurance companies and can increase the risk of market conduct or compliance problems during a period of adjustment. Similar problems can result from internal changes in a company, such as where, how and what lines of business it writes. Conversely, disruptions in a market sector or stresses or irregularities in a particular company’s operations will also leave their mark in the statistics.

Many changes are positive and a market with no signs of change would be troubling. Nevertheless, significant signs of change deserve careful regulatory attention, at least until their causes and effects are better understood. Even when changes are undeniably for the better, changes may, however, highlight areas where some companies have not adapted as well as others to the evolving marketplace.

In order to assess the nature and extent of changes, it is essential to have meaningful data. This section of the handbook explains the use of the NAIC iSite+ system and then discusses a few key items of information, such as consumer complaint data and state-by-state data from insurers’ financial statements that are most likely to be indicators of market conduct problems. Other significant sources of available data are also discussed briefly.

The importance of data begins at the very earliest stages of the process. Because state resources are finite, one of the most critical market analysis functions is setting priorities for review. Almost all states have over 1,000 insurers licensed to do business, so without a good sense of priorities, it can be daunting for a state insurance department to identify which companies to look at and what to look for. Because companies with a larger market share will impact the greatest number of consumers, an effective regulatory review program must include the companies with the largest market shares, while at the same time being careful not to overlook concerns that may arise with smaller companies.

Market share reports are among the wealth of data compilations that the NAIC makes available to state regulators on iSite+. For example, if a single company writes 25 percent of a significant line of insurance in a regulator’s state, this company is a market leader to which regulators should pay attention for that reason alone. However, the same companies are likely to be targeted in other states, which makes multistate coordination imperative, not only to avoid imposing unnecessary regulatory burdens upon insurers, but also to facilitate a deeper and more coherent analysis by the various regulators so as to address as efficiently and consistently as possible the company’s activities in all states where it does business.

Other factors for state regulators to consider when setting priorities include consumer complaint activity and the lines of insurance transacted. Some lines of insurance are more prone than others to particular types of market conduct problems. A more proactive market regulation program is generally better suited to personal lines than to commercial lines and generally better suited to small business markets than to other commercial lines markets. However, none of these criteria should be applied too rigidly. There is no foolproof way to predict which market issues will rise to the forefront, as demonstrated, for example, by the impact of the COVID-19 pandemic on both health insurance and business interruption insurance.

B. NAIC iSite+

The iSite+ suite of applications are used to report financial, market regulation and producer information housed in the NAIC databases. Regulators should familiarize themselves with iSite+, a secure regulator-only area within the NAIC website which provides access to NAIC databases and a wide variety of reports prepared from those databases. Of particular importance to market analysis are consumer complaint data and annual statement information.
iSite+ provides state insurance department regulators with access to applications used by regulators. Regulators may access iSite+ via the myNAIC link on the NAIC website. In order to log into myNAIC, regulators must have an active NAIC login credential.

iSite+ reports are standardized reports that provide regulators with a variety of financial and market regulation information. Summary reports provide information related to a group of entities with similar attributes (e.g. companies that write business in a particular state), Company/Firm reports provide information related to individual entities. A comprehensive listing and description of available iSite+ reports are located under the Tools tab.

C. Use of Complaint Data in Market Analysis

One of the primary missions of state insurance departments is to serve and protect the insurance consumer. To fulfill that mission, state insurance departments provide the valuable service of working with consumers and insurers to address consumer complaints. For lines of business where the insurance department has an active complaint resolution program, such as automobile, homeowners and health, consumer complaints should be a key starting point both to identify emerging issues and to screen insurers for potential market conduct or compliance problems.

Of all the types of information that departments initially collect for other purposes, consumer complaints have the most obvious relevance to market conduct. The goal here is to take the information we learn when doing complaint resolution and put it to work for complaint prevention.

The efficient use of a complaint analysis system allows an insurance department to create an effective and immediate surveillance program by detecting potential problems on both individual company and industry-wide levels. This complaint information is used by the states as an early warning system to detect problems and to provide a basis for further market conduct review. However, despite the obvious correlations between consumer complaints and market conduct concerns, regulators must be careful not to jump to conclusions purely on the basis of complaint data, nor should they conclude that the absence of complaints means an absence of market problems. There are a number of reasons why an exclusive focus on consumer complaints cannot be used as a substitute for a more thorough inquiry into the company’s activities, including:

- Complaints are to some degree anecdotal and often are not documented in sufficient numbers to be statistically credible. Although this deficiency can be mitigated to some degree by using multistate data, inconsistencies between different state approaches raise other concerns;
- One reason for the small sample size is that not every problem gives rise to a documented complaint. States need to gauge how informed state consumers are about voicing concerns or complaints regarding insurance;
- Conversely, the customer might not always be right. The presence of a complaint points to the existence of a conflict, but not the nature or the cause. A complaint could be the result of an insurer failing to live up to its obligations or the result of a breakdown in communications, but it could also be the result of unrealistic expectations on the part of the consumer. To address this concern, “confirmed” complaints, meaning complaints that have been confirmed by the the state insurance department as the insurer as being in violation or in error, (Link to definition in chapter 7) should be distinguished from other consumer complaints;
- There are some lines of insurance for which there are no useful complaint records because the nature of the business makes it unlikely that consumers will file complaints or because the insurance department does not have an active complaint resolution program. For example, violations of disclosure requirements might never generate complaints because, in the absence of disclosure, consumers do not know their rights have been violated. Similar problems also arise when premiums or benefits involve complex calculations because of the nature of the product; and
• Some markets are inherently more prone to complaints than others. For example, this is likely to be true for the higher risk or non-standard sector within any line of insurance. Such differences must be taken into account before trying to compare the performance of different companies serving different markets. When there are problems with life insurance products, they are less likely to become visible through the consumer complaint process. Similarly, complaints are more likely in lines of business where consumers have more frequent interactions with their insurer, such as health or private passenger auto, regardless of how serious the potential problems might be.

Nevertheless, complaint information is still the single most useful source of currently available data for market analysis. Complaints provide a great deal of information about the industry, individual insurers, and real-time consumer concerns, including emerging issues in the marketplace.

Complaint information is one factor that should be considered in the selection of companies for further review and in the determination of the nature and scope of that review. Identifying companies with consistently high levels of complaint activity can be a first step toward corrective action. Once an insurance department has determined that a problematic complaint trend is occurring, complaint data may be helpful in resolving issues for consumers in a number of different ways. Insurance department staff may want to meet with the company to review adverse trends and require the company to establish a compliance plan, which may include self-audits and refunds to consumers.

Even in cases where a company turns out to have done nothing wrong, complaints serve as a compass pointing toward those issues where consumers need enhanced knowledge and awareness, allowing regulators to target efforts, such as publishing brochures, speaking engagements at schools and community groups, and placing public service announcements in the media.

Whatever system of recording and classifying complaints is used, complaint analysis must relate the raw complaint data to a meaningful analysis. Therefore, the centerpiece of a basic market analysis program should be the development and use of reports compiling, summarizing, and comparing complaint information about the companies in a regulator’s state marketplace.

The efficient use of a complaint tracking system as part of an insurance department’s market conduct surveillance system allows an insurance department to create an effective and immediate surveillance program in detecting problem areas on an industry-wide level and in isolating potential problems for an individual company. Any complaint system used by the complaint division of an insurance department, in order to be efficient and meaningful, must be tabulated at least quarterly and preferably on a monthly basis. If a longer period is used, trends will not be spotted in a timely manner and the statistics that are generated will only show proof of an existing problem. From the tabulations, the complaint division can readily detect problems by using comparisons of past performance from past statistical information on an industry-wide level, by line or from individual companies.

The NAIC recommends the use of the Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act (#884). The purpose of the regulation is to prescribe the minimum information required to be maintained in a record of complaints in order to comply with the statute, and to set forth a format for a complaint record that may be used by any entity subject to the regulation. A complaints register/log, should be available at the offices of the insurer. Information from this register/log can be obtained during field examinations of the company or on request from the home office of the company. The register/log is primarily a management tool for insurance companies, but may help alert insurance regulators to problem areas within entities subject to the regulation.
Chapter 6—Basic Analytical Tools

In October 1991, the NAIC released the Complaints Database System (CDS). The CDS provides regulators with online access to a database, which consists of the complaints data collected from NAIC members. The database enables insurance departments in all jurisdictions to inquire about and analyze closed complaints filed against insurance firms and individuals within and/or across state boundaries. Additionally, the system provides summary reports and complaint ratios for NAIC members. States submit closed consumer complaints information to CDS on a monthly or quarterly basis. The complaint records are then aggregated on a regional and national basis, providing total complaint counts, trend analysis and complaint index rankings to state regulators.

Supplemental information regarding the Complaints Database System (CDS), such as complaint data fields and user guides, is available on StateNet. The most current version of the NAIC standard complaint data form is also available on StateNet on the Market Data Team (MIS) web page.

Although the focus of analysis is on patterns and trends, some individual complaints by their nature will raise serious questions about an insurer’s conduct, which call for follow-up even if the company’s complaint index and complaint trends are otherwise unremarkable. This underscores the need for effective communication between divisions. Insurance departments should establish criteria for their complaint analysts to use in identifying complaints, which should be called to the attention of their market conduct and/or enforcement staff for further review. Inquiries from producers, consumers, or health care providers about particular business practices may also warrant the attention of market regulators.

D. Use of Annual Statement Data in Market Analysis

Market Conduct Annual Statement
Similar to a Financial Annual Statement, the Market Conduct Annual Statement (MCAS) provides regulators with market conduct information not otherwise available on a regular basis. The first MCAS was adopted by the NAIC in 1991. It was designed as an aid in targeting examinations, as well as an alternative to examinations. MCAS data collection has grown from one area within one line of business, private passenger auto claim payment information, to multiple market regulation concerns within multiple lines of businesses.

Currently, MCAS data is collected on eight lines of business: individual life cash and non-cash value products; individual fixed and variable annuities; individual stand-alone and hybrid long-term care policies; private passenger automobile policies; homeowners policies; in-exchange and out-of-exchange health plans; lender placed home and automobile policies; and disability income. In addition, the collection of private flood MCAS data will begin for the 2020 data year reported in 2021. Travel insurance and other health MCAS will be reported in future years.

By using common data and analysis, states have a uniform method of comparing the performance of companies. Data is collected regarding claims, premiums, policies in force, new policies written, nonrenewals, cancellations, replacement-related activity, suits and consumer complaints on an industry-wide basis. If a company's performance appears to be unusual as compared to the industry, the state may undertake further review of that company. The additional review may be as simple as calling the company for further information or clarification or conducting further analysis.

Additional information regarding the Market Conduct Annual Statement program may be found at https://www.naic.org/mcas_main.htm or by contacting NAIC Market Regulation Department staff at mcas@naic.org.

Financial Annual Statements and State Pages
The most comprehensive source of data on the financial aspects of insurers’ activity in the marketplace are the annual and quarterly financial statements, which an insurer is required to file with its state of domicile, the NAIC and, in most instances, all jurisdictions in which the insurer is authorized to transact business. These statements include specific schedules and interrogatories that provide detailed information, such as premium volume, losses, and changes in business. The NAIC compiles a wide variety of reports from the filed financial statements and makes them available to state insurance departments at iSite+. Financial statement data has value for market analysis on
several levels and sometimes will allow regulators to identify companies with an increased risk of future compliance problems, allowing regulators to respond proactively before serious problems occur.

Most directly, financial information is meaningful to market regulators because market activity takes place through financial transactions. Although the dollars and cents, especially when aggregated at the statewide or nationwide level, do not by any means tell the whole story of a company’s underwriting, sales, rating, risk classification and claims-handling practices, the underlying financial information is systematically collected and quantified in a consistent manner and suitable for use as a starting point for further analysis.

Certain types of consumer problems tend to be accompanied by characteristic patterns in company-specific or aggregate financial data. Indicators of financial stress should also be of concern to market analysts because financial problems are often accompanied by market conduct problems, such as delayed claims payments and neglect of customer service. Furthermore, the failure, retrenchment, or reorganization of a major market presence will have a disruptive effect on the market as a whole.

Every insurer, as part of its annual statement, files a State Page in each state in which it is licensed. The financial data of greatest general interest to market analysts can be found there, with the caveat that State Pages do not capture potentially significant information on geographic units within the state. The content of the State Page varies by product line, but generally, it is an exhibit of premiums and losses.
For property/casualty insurers (which file on the yellow statement Blank), this page is, for historical reasons, referred to as “Statutory Page 14.” This page is officially called “Exhibit of Premiums and Losses—Statutory Page 14.” The page no longer appears on the actual page 14 of the property/casualty Blank. On the life and accident and health (blue) statement, the State Page is commonly referred to as “Page 15.” The actual location of the page changes from year to year. In the health (orange) statement, the State Page is officially titled “Exhibit of Premiums, Enrollment and Utilization.” And, as with the other Blanks, its actual location varies. On the health State Page, the company reports statewide earned and written premiums, incurred and paid losses and other key information, broken down by line of business. The reporting format will vary depending on the type of annual statement the company files, as will the additional information requested. For example, the property/casualty Blank includes entries for direct defense and cost containment expense, commission and brokerage expenses and taxes, licenses and fees, while the health Blank reports total members, ambulatory patient encounters, inpatient admissions and hospital inpatient days incurred.

Claims-related information is of particular relevance to market performance, so one of the key items of financial data for market analysts is claim reserves, which is itemized on the property/casualty Blank as “Direct Losses Unpaid” and “Direct Defense and Cost Containment Expense Unpaid.” A spike in reserves can occur for a number of reasons, some of which might signal market conduct problems. If losses and reserves are both moving in the same direction, there is less concern. A spike in reserves without a corresponding change in losses paid should be investigated. Perhaps a major lawsuit was filed against one of the company’s insureds, or there may be a correction of reserves on pending claims. The insurance regulator should investigate the reason and also check the complaints made against the insurer, trends over time, and reserve activity for comparable companies in the market.

For liability insurers, significant changes in defense costs may be an indicator of market conduct problems if it shows that a disproportionate share of claims are going into litigation. This information, like changes in reserves, must be looked at in its proper context in order for it to be used effectively as a market indicator. If the increase in defense costs correlates with increases in premium volume and losses, there is less concern. An inquiry should be made when defense costs are rising disproportionately to direct losses. Although less common, similar concerns may also be raised by unusual loss adjustment expense activity in other lines of business.

The premium information enables the calculation of the company’s market share for each line of business or for the market as a whole, by dividing the company’s premium by the market aggregate. Market share information allows regulators to quickly identify the companies with the most impact on the market—bearing in mind that these companies are by no means the entire market and smaller companies and their consumers cannot be ignored. In addition, comparing market share information over time allows regulators to identify companies whose operations in the state are expanding or contracting and to inquire further into the reasons for the change and whether the company has the resources to deal effectively with rapid growth or with lost business. States should analyze at least three to five years of historical data to place the information most recently reported in its proper context. For example, California provides a market share history on its website for insurers actively writing property/casualty, life/annuity and title business there.

Financial statement data also allows the analysis of how a state fits into the company’s overall operations, what the rest of its market looks like and how that pattern compares to other companies doing business in a regulator’s state marketplace.

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3 Although this information may also be of value when studying accident and health insurers, particularly in lines like long-term disability and long-term care, there is no analogous line item on the health or life and health state pages. Because calendar year paid loss data aggregates layers of the losses incurred in many different years, unpaid losses cannot be backed out by comparing calendar year paid and incurred loss data.
From the State Page data, a regulator can run three categories of reports: Aggregate Reports; Detail Reports; and Market Share Reports. Aggregate Reports includes two kinds of reports: (1) Credit and A&H Pure Direct Loss Ratio; and (2) Lines of Business by State. Detail Reports include: By Line of Business; Life Premium & Annuity Considerations; Life Summary; PA& or Health Summary by Line of Business; and Unlicensed Premiums: Market Share Reports can be run on: A&H; Credit A & H; Credit Life; Life & Annuity; and By Line of Business. The Aggregate Report for Credit and A&H Pure Direct Loss Ratio can be tailored to data year (2010 to current). The loss ratio information will help identify companies with greater contact with consumers through the claims settlement process and significant deviations from the norm could indicate financial stress if the loss ratio is too high—or the potential for concerns about claim handling or underwriting practices if the loss ratio is unusually low. It must be kept in mind, however, that what might be considered a “normal” loss ratio—consistent with profitable operations—may vary significantly, depending upon the line of business and (especially for “long-tail” lines of business) upon changes in general economic conditions. The Aggregate Report By Line of Business can be tailored to data year (2010 to current) and statement type (property, life and health).

The Detail Report for Lines of Business can be tailored by data year (2010 to current), statement type (property, life, life – A&H, and Health), financial amount (e.g. direct premiums written), and multiple unique sub-types of business (e.g. private crop under Property; industrial under Life; federal employees health benefits plan premium under Life – A&H; and dental only under Health).

The Insurance Regulatory Information System (IRIS) tool, based on financial statement data, should also be noted. IRIS ratios are available for Fraternal, Property, and Life companies. The IRIS Worksheet calculates acceptable ranges for twelve ratios and notes when a company falls outside of that range. A company that consistently has multiple unusual IRIS values or fails to improve those ratios is of concern. Although the IRIS ratios were developed to assist solvency regulators, they also capture some information that can be useful to market analysts.

E. Issues Specific to Particular Types of Companies

As we have seen in the discussion of financial information, different types of insurers engage in different activities that make different types of information relevant. The most pronounced differences are reflected in the distinctions between the two major annual statement formats—property/casualty and life/accident/health—but there are also issues specific to particular lines of business that regulators need to take into consideration.

Health Insurance

In many insurance departments, there are consumer assistance resources dedicated specifically to health insurance. These areas may have more extensive complaint information, and the complaint information in most states will be supplemented by external review information. At the same time, however, the relevant financial statement information will be more fragmented, because this market uniquely comprises companies filing on all three types of annual statement Blanks. In addition, self-insured employers (which are exempt from state regulation) provide a substantial proportion of health coverage and consumers are not always aware that this coverage is not insurance. The Health Insurance Portability and Accountability Act (HIPAA) and Employee Retirement Income Security Act (ERISA) play a unique role in this area of coverage and there are also significant state-to-state variations in laws regulating access to individual coverage, mandated benefits and individual and small group rating practices. Property/Casualty Insurance

Personal lines property/casualty coverage is another key focus of consumer assistance and complaint resolution programs. A high proportion of consumer concerns in these lines of business relate to claims and to policy termination, and often the two go together. This is a dynamic market with many emerging issues. There are also significant state-to-state variations in property/casualty lines of business. Many of the variations in the liability insurance markets reflect variations in the underlying substantive laws giving rise to the liability exposure. This is especially true for automobile insurance, where several states have modified the traditional tort law for automobile collisions with some form of “no-fault” coverage.
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Life Insurance

The coverage structure and company finances for life insurers are notably different from other types of insurance. Proportionately, market conduct problems with life companies are more likely to arise on the sales side and less likely to arise on the claims side than in other lines of insurance. In life insurance, there is significantly less interaction between the company and the consumer over the course of a customer relationship than with other lines of insurance. Market conduct problems are often less likely to surface promptly in the form of a consumer complaint.

Workers’ Compensation Insurance

In this line, market conduct issues may involve either the insured (the employer) or the claimant (the employee). This is true to a lesser degree for other third-party coverage, particularly auto insurance in tort states, but workers’ compensation insurers in most states have statutory obligations to claimants that liability insurers do not have. The experience rating system gives the employer a more direct interest in claims practices, and there are unique jurisdictional issues in states where workers’ compensation claim handling is the primary or exclusive responsibility of the state workers’ compensation agency rather than the insurance department.

F. Other Useful Information

While complaint records and financial statements may be the most comprehensive and concentrated sources of data on market activity, there are many additional sources that should be reviewed in order to obtain the complete picture of a company or an industry. For example, a high proportion of the activity in the insurance marketplace involves licensed insurance producers. Records of disciplinary actions or appointment terminations may reveal patterns of questionable practices in certain market sectors or implicate certain companies. Even routine activities, such as increases or decreases in new licenses or appointments or changes in lines of authority, can indicate market trends which might warrant further inquiry to evaluate whether the effects are positive, negative, or mixed. The information contained in this section of the handbook provides additional resources and tools for assisting with the analysis of a company..

Financial Reporting (Public and Private Sector)

Statutory annual and quarterly statements are the principal source of financial information on insurers, but they are not the only source. If the insurer is publicly traded, it will also be filing with the U.S. Securities and Exchange Commission (SEC). Filings can be accessed at the SEC website using EDGAR at https://www.sec.gov/edgar/search-and-access. The most useful filings for market regulation purposes are: 10-K and 10-Q; 8-K; and 4. There are a variety of private-sector sources that compile and evaluate financial information, such as rating agencies, statistical and ratemaking advisory organizations, trade associations, securities analysts, and academic and nonprofit research institutions. Some of these data compilations are directed towards specialized information, such as claims activity,. Surveys and reports on particular topics by research institutions, consumer groups, and trade organizations may also yield valuable data.
Rating Agencies
The principal rating firms that measure insurance companies’ financial strength: A.M. Best Company, Moody’s Investor Service, Fitch Ratings, NAIC’s Securities Valuation Office (SVO), Standard & Poor’s Global Ratings, and Weiss Ratings. It is common for a company’s compliance or marketing strategies to change when there is a rating decrease by one or more of these rating agencies. Market analysts should review a company’s financial rating from each of the main financial rating firms to determine if there is a possible correlation between a downgraded rating and market regulatory practices. It is important to note that ratings should be reviewed independently for each rating organization. For instance, a company may receive a high rating from Standard & Poor’s or Fitch Ratings, but fail to receive a high rating from A.M. Best. There are also variances in the areas rated by each rating firm and analysts should consider the areas of review and the methodology of the rating organizations. Market analysts are encouraged to review rating changes over a period of five years for substantive changes.

Informational Filings
All insurers are subject to state licensing and holding company regulations. Under these laws, state insurance departments will receive notice of changes in corporate officers and directors, changes in the domicile of insurers in the holding company group and reports on significant transactions among an insurer and its affiliates. These changes are rarely, if ever, indicators of market conduct problems by themselves, and material transactions in most cases have already been subject to regulatory review. However, when other indicators show warning signs, it is often useful to take a second look at holding company regulation statements and company licensing information, such as updates of director and officer information, to see if certain information that did not seem noteworthy at the time takes on a new meaning in hindsight. If a state insurance department collects or reviews them, companies’ underwriting and claims manuals may contain useful information, though it must be kept in mind that such manuals are generally regarded as proprietary and, as such, should be protected from public disclosure. Attention should be paid to changes in underwriting guidelines since this provides real-time information on market practices the companies themselves have identified as important.

Interdepartmental Communication
A continuous dialogue with regulators in other areas within a department of insurance is essential, as issues arising in other areas may be mirrored by related problems consumers are having with the same companies or markets. For lines of business that are subject to form or rate review or certification, incidents where a company has been observed using unapproved or improperly certified rates or forms should trigger further inquiry, since such incidents often are part of a wider pattern.

Communication with other Regulators
Communications with other state agencies, other state insurance departments, and the federal counterparts is instrumental in maintaining a seamless review of companies, keeping a fair playing field, and providing the most protection to consumers.

Enforcement Actions
In particular, significant enforcement actions against a licensed insurer or examination reports with findings of violations (keeping in mind that these could be from financial examinations, not just from market conduct examinations), are clearly of major interest from a market analysis perspective, whether they arise in a regulator’s state marketplace or in another state where the company does business. A consumer complaint or even a pending regulatory proceeding is of interest, especially on a cumulative basis, but in and of itself does not necessarily mean the company has done anything wrong. However, a disciplinary order or a finding of violations is a more serious matter, even though it may be based on different laws or market conditions. Likewise, a record that a company has been or is being investigated by several different states for similar reasons raises questions every bit as serious as the questions raised by a high complaint index.
Chapter 6—Basic Analytical Tools

Regulatory Information Retrieval System
The NAIC Regulatory Information Retrieval System (RIRS) tracks adjudicated regulatory actions for companies, producers and agencies. The origin, reason and disposition of the regulatory action are recorded in the RIRS database. RIRS is an essential resource for market regulators and states should ensure its high quality by taking care to report all adjudicated regulatory actions to RIRS. It should be kept in mind, however, that because enforcement actions are considerably less frequent than consumer complaints, they do not lend themselves well to ratios or other quantitative techniques. For most companies in most years, the percentage of premiums paid out as fines or restitution will be zero—and simply tracking the number of enforcement actions may give too much weight to minor violations, such as isolated cases of late reporting. The most recent version of the RIRS submission form is available on StateNet on the Market Data Team (MIS) web page.

Market Action Tracking System (MATS)
Information regarding market conduct examinations and other market conduct initiatives may be quickly obtained on iSite+ through the Market Action Tracking System (MATS) Detailed Report, which provides a history of market actions matching specified criteria. A report may be generated displaying all market conduct actions originating in a specified state for a specified date range. MATS includes not only actions related to market conduct examinations, but also non-examination regulatory interventions or inquiries. MATS Reports can also be run specific to an individual company.

Self-Audits and “Best Practices” Reviews
Reports from voluntary examinations of companies provide another potential source of useful market analysis information at any stage of the analysis process. In addition to self-audits conducted by companies, evaluations are also prepared when insurers apply for membership or accreditation to “best practices organizations” or independent standard-setting organizations and when those organizations conduct periodic reviews.5

It must be kept in mind, however, that such evaluations are a supplement to regulatory analysis and not a substitute, and that an organization might not set comprehensive standards for “best practices” across the entire field of operations, focusing instead on particular areas such as marketing and advertising. Market conduct analysts and examiners should be conversant with the standards required to qualify for membership in organizations such as the National Council on Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) (for health insurers). State insurance departments should review these standards to evaluate the extent to which compliance with the standards can be considered as a relevant indicator of compliance with related state statutes and regulations, to refine the market analysis. States are encouraged to direct analysts and examiners to request information associated with these organizations’ assessment activities to determine how such information might be used to gauge the appropriate nature and scope of further market conduct review that may be indicated.

Some best practices organizations have developed standardized reporting formats, which are designed to provide market conduct analysts and examiners with a comprehensive summary of the testing and review activities that take place during a company’s self-audit and/or independent review process. Market conduct analysts and examiners are encouraged to become conversant with the specific review standards applicable to the independent analysis. Work papers retained by the company or its independent reviewer may provide additional useful information for market analysis purposes. Regulators must be sensitive, however, to the confidentiality concerns raised by these materials, as discussed in the NAIC white paper, Regulatory Access to Insurer Information: The Issues of Confidentiality and Privilege. Personnel who work with confidential material should be specifically trained in the applicable laws and in the agency’s procedures for protecting confidential or privileged information from public disclosure, whether it is maintained in paper or electronic form.

In some states, self-evaluative privilege statutes provide specific guidance on the regulators’ access rights and confidentiality obligations, whereas regulators in other states must consider a variety of issues related to the protection of proprietary information, attorney work product, trade secrets, and other privileged information.

5 Market analysts should refer to the NAIC white paper Best Practices Organizations for additional guidance related to the application of such evaluations and standards.
Addressing these concerns and working with companies’ voluntary review activities is important, because a full understanding of a company’s market activities encompasses the company’s policies and the practices that implement the company’s policies. An active compliance program at a company often reflects a corporate culture that places a high value on compliance. Since “bottom-up” information on a company’s market practices is more accessible to regulators, the “top-down” policy focus often found in insurer peer reviews can be a useful complement to the information that is otherwise available.

**Consumer Dispute Resolution Processes**
For some lines of insurance, statutory dispute resolution processes provide another useful source of market information. In particular, most states now have some sort of external review framework for health insurance claims disputes; regulators should review the records of external review requests, disposition, and companies’ responses over time. Similarly, records of administrative hearings on cancellations or nonrenewals of property insurance and automobile insurance policies (in states where these activities are subject to regulatory review) may shed some light on market practices in these lines of insurance.

**Matched Pair Testing**
For homeowners insurance, market conduct analysts should consider the use of matched pair testing to evaluate whether geographic areas with a relatively high percentage of persons in protected classes are receiving the same level of service and availability and quality of product as residents of nearby geographic areas which have different racial or ethnic characteristics. The number of matched pair tests conducted for this purpose does not need to be statistically significant, as the tests are designed to be a snapshot of the way in which a specific company is operating at a specific moment, and not an evaluation of the marketplace as a whole. In matched pair testing for homeowners’ insurance purposes, two houses of similar age, construction type, style, and maintenance level, but in different racially identifiable neighborhoods, are used as the basis for the test. Trained testers, whose race matches that of each neighborhood, call an insurance agent just as a bona fide homeowner would, and identify themselves as a homeowner or buyer. They request information and quotes about homeowners insurance, track the responses, and fill out a report which is submitted to the person coordinating the test, along with any written materials subsequently received from the insurer. The test coordinator reviews the results of both contacts and compares the treatment in each case to determine whether both callers were treated equally. (The same general concept of comparative treatment applies to auto insurance and can be executed using testers with similar driving records calling about similar cars). While the concept is simple and straightforward, quality of execution is important, and market conduct analysts should consider contracting with an entity experienced in the conduct of insurance testing, such as the National Fair Housing Alliance (NFHA). They may also use their own staff or contract testers. Training in how to conduct such tests should be sought from NFHA or other qualified organizations.

**Rating Territories**
An evaluation of the way in which the market is being served for homeowners and auto insurance should include overlaying rating territories with census maps, to determine whether the rating territories have been designed in such a way that makes it likely that persons in protected classes will pay higher prices than residents of predominately Caucasian or higher-income areas. If that appears to be the case, information on loss data should be gathered to determine whether the higher costs are justified.

**Miscellaneous**
Anecdotal information of useful interest may even be found in such unexpected sources as a state insurance department human resources division, which might have useful information, since an influx of applicants from a particular company could be a sign of stress. At the same time, regulators in various divisions of a state insurance department need to communicate on relevant issues. For example, claim delays or disputes could be a symptom of financial stress and repeated consumer complaints relating to particular policy language may suggest that an insurance department reconsider its approval of such clauses.

Other information collected by some regulators, though not necessarily available in all states, includes underwriting guidelines, detailed geographic market performance data, surveys of market participants and marketplace testing. Detailed geographic data—such as ZIP code data by company and type coverage—has been used by some regulators to identify underserved markets and investigate redlining allegations. Surveys of market participants—including agents, realtors and consumers—are another source of real-time market performance information. Testing—sending
people to purchase insurance who have similar risk characteristics but different races or other characteristics that may make them targets of unfair discrimination—adapts a tool that has long been used in the fields of housing, lending and employment to verify compliance with fair practices. In addition, a review of recent insurance-related lawsuits can provide insight into consumer perceptions of market abuses, and this information is publicly available.

Market regulators should keep their eyes and ears open outside the office as well. Valuable information can arrive in structured formats—such as regulatory meetings, continuing education programs, email discussion groups, and news feeds—and also in less structured environments, ranging from stories about lawsuits to interesting names in the news and chance remarks by acquaintances. The more one knows, the better equipped one is to ask the next question.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 19, 2021. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Teri Mecca (AR); Sarah Borunda (AZ); Don McKinley (CA); Kurt Swan (CT); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Sandra Stumbo (KY); Jeff Zewe (LA); Mary Lou Moran (MA); Dawna Kokosinski (MD); Timothy Schott (ME); Jill Huisken (MI); Jo LeDue (MO); Robert McCollough (NE); Edwin Pugsley (NH); Ralph Boeckman (NJ); Leatrice Geckler (NM); Hermoliva Abejar (NV); Larry Wertel (NY); Landon Hubbart (OK); Jeffrey Arnold (PA); Matt Gendron (RI); Michael Bailes (SC); Shelley Wiseman (UT); Will Felvey (VA); Christina Rouleau (VT); and Theresa Miller (WV). Also participating was: Sarah Crittenden (GA).

1. **Adopted its Feb. 25 Minutes**

Mr. Haworth said the Working Group met Feb. 25 and took the following action: 1) adopted its Jan. 27 minutes; 2) discussed a 14-day limitation for Market Conduct Annual Statement (MCAS) extension requests; 3) discussed the MCAS attestation process; and 4) discussed training opportunities for market regulation analysts.

Mr. Pugsley made a motion, seconded by Mr. Boeckman, to adopt the Working Group’s Feb. 25 minutes (Attachment Three-A). The motion passed unanimously.

2. **Adopted Revisions to the MCAS Best Practices Guide**

Ms. Rebholz said during the Working Group’s last meeting, it discussed the completion of the **MCAS Best Practices Guide**, and the final draft was posted on the Working Group’s web page. She said the most significant changes are: 1) the recommendation to limit initial and subsequent extension requests to two weeks; 2) highlighting “best practices” within the document; and 3) adding an appendix to summarize all the recommended best practices. She said the drafting group also inserted a table of contents for ease of reference. She noted that no comments were received on the draft.

Mr. McKinley made a motion, seconded by Mr. Bailes, to adopt the revisions to the **MCAS Best Practices Guide**. The motion passed unanimously.

3. **Adopted a 14-Calendar Day MCAS Extension Limitation**

Mr. Haworth said the Working Group has discussed the 14-day extension limitation during its last two Working Group meetings. He said the proposal is to limit extension requests to 14 days but continue to allow companies to ask for additional extensions if needed. He said to accomplish this, the MCAS filing tool, which is used by companies to file their MCAS submissions, would need to be re-coded to limit extension requests to 14 days and allow for multiple requests after the initial extension request. He noted that because of the re-coding, if the Working Group adopted the proposal, the soonest it could take effect is for 2021 data collected in 2022, but considering other market information system priorities, it may be later. He noted, however, that any MCAS jurisdiction can still choose to only allow 14 days for any extension request.

Mr. Haworth said his sense is that state insurance regulators are in favor of limiting extension requests to 14 days. Industry, however, proposed making the proposal 14 business days. Mr. Haworth said the Working Group received one comment from a state that is comfortable with 15 business days, which on the calendar would be three weeks. He said during the February meeting, several members of the Working Group noted that if the final day of an extension fell on a weekend or holiday, the jurisdiction would allow the filing on the following business day.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said companies would like to have the ability to request extensions up to 60 days. She said the reliable filers start the process early, and they usually would not request an extension except in unusual situations where more than 14 days might be required. For reliable filers, extensions are not requested because of bad planning, and 14 days may not be enough time.
Birny Birnbaum (Center for Economic Justice—CEJ) said a company that is diligent in preparing its MCAS submission would not discover that it needs more time in the last days of the filing period and would not need 60 additional days after the due date. He said he supports the 14-day limitation. Ms. Brown said if the reliable MCAS filers find an issue with their data in the last days before the due date, it generally is not a 14-day fix.

Mr. McKinley asked if companies would be able to request additional extensions if 14 days are not enough. Mr. Haworth said the MCAS submission tool would be re-programmed to allow additional requests.

Mr. Gendron requested that the 14-day extension be referred to as a 14-calendar day extension. He said Rhode Island had no preference for either a 14-calendar day extension limitation or a 15-business day limitation. He said Rhode Island is willing to provide the time required to get accurate data. Mr. Haworth noted that the longer the market analysts must wait for the data, the more often they have to refresh the data they are using for their analysis. Ms. Crittenden said she is in favor of referring to the limitation as “calendar days,” and she said market analysts need accurate data as soon as possible.

Ms. Keller made a motion, seconded by Ms. Rebholz, to limit MCAS extension requests in the MCAS submission tool to 14 calendar days and allow for additional extension requests. The motion passed unanimously.

4. Adopted an MCAS Requirement to Attest by Line of Business and by Jurisdiction

Mr. Haworth said the Health Insurance Interested Parties (HIIPs) made a request to be able to identify a different attester per line of business and per state. This request was supported by representatives of companies in the other lines of business.

Mr. Haworth said currently, a company filing its MCAS submissions must have two attesters—one attester to the accuracy and completeness of the MCAS filings and one attester to the company being able to track the data to its source and re-create the results in MCAS filing. He said these two attesters are the same for all lines of business and all states. This causes concerns for companies that have different responsible people for different states and different lines of business.

Mr. Haworth said NAIC staff support advised the Working Group that this can be accomplished by placing the attestations within the blank itself and removing the separate attestation section. The wording of the attestation would be contained in the Data Call and Definitions for each line of business. No MCAS filing could be submitted without attesters being identified, but failure to provide attesters in one state or line of business would not stop other filings from the same company if those other filings had the attesters properly identified.

Mr. Haworth noted that the Working Group also had a conversation about whether the attesters should be officers of the company. He said he is setting that discussion aside until the Working Group votes on whether to allow for different attesters per line of business and per state.

Samantha Burns (America’s Health Insurance Plans—AHIP) said AHIP supports two attesters per line of business and per state. She also said the company should have the discretion as to who the attesters are.

Ms. Brown said she appreciates the needs of the health insurers, but having to name attesters for every filing would result in more work for national companies that have been filing for a long time with no need to differentiate by line of business or by state. Randy Helder (NAIC) said the change would only result in four additional lines to be completed on a comma-separated-values (CSV) upload. Teresa Cooper (NAIC) said the NAIC provides a CSV Assistant for companies on the MCAS web page to make the creation of the CSV simpler.

Mr. Birnbaum said he supports the change because it makes it more efficient for state insurance regulators to contact the correct people on each filing.

Mr. Schott made a motion, seconded by Mr. Pugsley, to allow companies to identify their attesters by line of business and by jurisdiction.

Ms. Brown asked that the motion be re-phrased to “require” companies to identify their attesters by line of business and by jurisdiction because companies will no longer have the option to use the attestation page.

Mr. Schott and Mr. Pugsley agreed to change the motion to allow companies to identify their attesters by line of business and by jurisdiction. The motion passed unanimously.

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5. Adopted Revisions to the NAIC Market Regulation Handbook

Mr. Haworth said the revisions to the market analysis chapters of the NAIC Market Regulation Handbook were completed prior to the Working Group’s last meeting, and they have been posted in the exposure drafts section of the Working Group’s web page. He said no comments have been received on the revisions.

Ms. Rebholz made a motion, seconded by Ms. Abejar, to adopt the revisions to the market analysis chapters of the NAIC Market Regulation Handbook. The motion passed unanimously.

6. Discussed Market Analysis Training

Mr. Haworth thanked Tony Dorschner (SD) for his written suggestions. He said those comments and others regarding training are posted on the Working Group’s web page. He encouraged others to put their thoughts in writing so they can be compiled. He said there is a study group of at least 40 people to learn how to conduct a level 1 review in the Market Analysis Review System (MARS). He said this is in preparation for the Market Actions (D) Working Group’s national analysis program.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Feb. 25, 2021. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Crystal Phelps (AR); Maria Ailor (AZ); Don McKinley (CA); Steve DeAngelis (CT); Cheryl Wade (DC); Frank Pyle (DE); Scott Woods (FL); Erica Weyhenmey (IL); Tate Flott (KS); Jeff Zewe (LA); Mary Lou Moran (MA); Dawna Kokosinski (MD); Timothy Schott (ME); Jill Huiskens (MI); Teresa Kroll (MO); Paul Hanson (MN); Jeannie Keller (MT); Reva Vandevenooe (NE); Karen McAllister (NH); Leatrice Geckler (NM); Hermoliva Abejar (NV); Larry Wertel (NY); Landon Hubbard (OK); Jeffrey Arnold (PA); Segun Daramola (RI); Rachel Moore (SC); Tracy Klausmeier (UT); Will Felvey (VA); Christina Rouleau (VT); and Theresa Miller (WV). Also participating were: Sarah Crittenden (GA); and Jo LeDuc (MO).

1. **Adopted its Jan. 27 Minutes**

Mr. Haworth said the Working Group met Jan. 27 and took the following action: 1) adopted its Nov. 12, 2020, minutes; 2) discussed a 14-day limitation for Market Conduct Annual Statement (MCAS) extension requests; 3) discussed the MCAS attestation process; and 4) discussed training opportunities for market regulation analysts.

Ms. Rebholz made a motion, seconded by Mr. Pyle, to adopt the Working Group’s Jan. 27 minutes (Attachment Three-A1). The motion passed unanimously.

2. **Discussed Revisions to the MCAS Best Practices Guide**

Ms. Rebholz said the group assigned to updating the MCAS Best Practices Guide (Best Practices Guide) has completed its work, and the revised version can be viewed in the exposure drafts on the Working Group’s web page. She said the version in the exposure drafts can be compared with the current version of the Best Practices Guide, which is in the Related Documents tab. She said the most significant changes are: 1) the recommendation to limit initial and subsequent extension requests to two weeks; 2) the highlighting of “Best Practices” within the document and adding an appendix to summarize all the recommended best practices; and 3) the creation of a table of contents for ease of reference.

Ms. Rebholz said after the changes to the Best Practices Guide, the group also reviewed other MCAS references to ensure consistency. This included the web page, the Frequently Asked Questions (FAQs), the call letter, and participation requirements. Ms. Rebholz said since these are supporting documents, the Working Group will not be voting on the changes to them. She noted that the changes to those documents were all technical.

Ms. Rebholz said the Working Group will keep the revised Best Practices Guide posted in the exposure drafts through the next conference call, and she invited comments through March 17. She said at the Working Group’s next meeting prior to the Spring National Meeting, it will vote on the revised Best Practices Guide.

3. **Discussed MCAS 14-Day Extension Limitation**

Mr. Haworth said the MCAS submission tool currently allows a company to choose up to 60 days for an extension request. The subgroup revising the Best Practices Guide is advising that all states allow no more than a 14-day, or two-week, extension. The drafting group is also asking that the MCAS tool be adjusted to only allow extensions for no more than 14 days at a time.

Mr. Haworth said it is possible that companies may need more than the 14 days. The MCAS tool will also need to be changed to allow companies to submit second or third requests. Mr. Haworth said this will require some programming work by NAIC Information Services. He said if the change is approved, the soonest it would be in effect would be for the 2021 data reported in 2022, but it might be the following year.

Samantha Burns (America’s Health Insurance Plans—AHIP) asked the Working Group if the extension could be for 14 business days. Mr. Flott said the Kansas Department of Insurance (DOI) typically only provides 14 days and if the 14th day falls on a
Saturday, Sunday or holiday, then the last day would be the following working day. He prefers calendar days rather than business days. Ms. Keller said she also prefers calendar days with weekends assumed to be the following Monday.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said it is important to have the ability to make a second or third request if limited to 14 days. She said the reliable filers start the process early, and they usually would not request an extension except in unusual situations where more than 14 days might be required. For reliable filers, extensions are not requested because of bad planning.

Mr. Haworth said the Working Group will vote on this issue on its next conference call. He asked that comments be sent to Randy Helder (NAIC) by March 17.

4. **Discussed MCAS Attestation**

Mr. Haworth said a mock-up was created of a solution that will allow companies to identify two attesters per line of business, per state. He said the issue is that currently a company can only submit the same two attesters for all lines of business in all states. This creates issues where companies may have different responsible parties for different lines of business or in different states. Mr. Haworth said the proposed solution is to move the attestation to the reporting blank so different attesters can be identified in every filing. He said the actual wording of the attestation will be in the MCAS Data Call and Definitions for each line of business, and it will be referenced on the blank.

Ms. Burns said the health insurer interested parties (HIIPs) were supportive of the proposed solution. She said it was a positive change, and she would like to see it move forward. Joseph E. Zolecki (Blue Cross Blue Shield Association—BCBSA) agreed, and he said it looked like a feasible solution to allow different attesters for different lines of business and states.

Ms. Crittenden asked if the attester could be required to be an executive of the company. Mr. Haworth said it is important that the attester be someone knowledgeable about the specific data being reported. Mr. Arnold said if the attester is too far removed from the data, they are only attesting to the best of their knowledge. Mr. Haworth said there are lines for two attesters, so it may be possible to require one to be an executive while the other is knowledgeable about the specific data. Mr. Helder said there are two attesters because one of the attesters is attesting to the accuracy and the other is attesting to the source of the data and the ability to re-create it.

Ms. Brown said a large nationwide company may have a significant amount of input if the reporting is done with the reporting blank.

Andrew R. Pauley (National Association of Mutual Insurance Companies—NAMIC) said these seem to be two separate issues: 1) who needs to attest; and 2) how the attestation is done. He asked if the solution is all or nothing. He asked if a company can still choose to attest on the attestation page with one attester responsible for all lines and states. Mr. Helder said the solution anticipates removing the attestation page and replacing it with data elements on the reporting blank.

Mr. Haworth asked for comments to be sent to Mr. Helder by March 17. He said the Working Group will consider adoption of the new attestation process at its next meeting.

5. **Discussed the Market Analysis Framework**

Mr. Haworth said the small group reviewing and updating the NAIC *Market Regulation Handbook* chapters on market analysis completed its work. He said the exposure draft section of the Working Group web page contains links to the redlined versions of Chapters 6 through 9.

Mr. Haworth asked everyone to review the drafts and send comments to Mr. Helder by March 17.

6. **Discussed Market Analysis Training**

Mr. Haworth said for the last few meetings, the Working Group has been discussing training suggestions that state insurance regulators would find helpful. He said the Working Group received suggestions from South Carolina, and those are posted in the comments on the Working Group web page.
Ms. Abejar said new analysts and examiners would be helped by training in market conduct risk identification. She said it would be helpful to know what risks are present when certain data is seen. She also suggested a repository to document situations and how they were handled to learn from experiences.

Ms. LeDuc suggested a lunch and learn format that is regularly scheduled but informal. State insurance regulators could bring problems they are encountering to the lunch and learn to discuss solutions and ideas. She noted that it is difficult to find training on problems right when it is needed. The lunch and learn would allow for quicker turnaround.

Ms. Ailor said the timing of training should match with the need (e.g., MCAS training is needed when filings are being received and analyzed).

7. **Discussed Other Matters**

Mr. Haworth said HIIPs also said in their comment letter that there appears to be a one-megabyte file size limitation when uploading filings in the MCAS. He said NAIC staff were unaware of this, but they have duplicated the issue. He said it will likely be an issue that the Market Information Systems Research & Development (D) Working Group will consider addressing and prioritize if any changes need to be made. He said NAIC staff will submit a Uniform System Enhancement Request (USER) for to the Market Information Systems Research & Development Working Group to begin that review.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

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The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Jan. 27, 2021. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Crystal Phelps (AR); Maria Ailor and Sarah Borunda (AZ); Don McKinley (CA); Damion Hughes (CO); Steve DeAngelis (CT); Sharon Shipp (DC); Frank Pyle (DE); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Sandra Stumbo (KY); Jeff Zewe (LA); Mary Lou Moran (MA); Dawna Kokosinski (MD); Timothy Schott (ME); Jill Huiskens (MI); Cynthia Aman (MO); Paul Hanson (MN); David Dachs (MT); Reva Vandevoorde (NE); Karen McAllister (NH); Ralph Boeckman (NJ); Leatrice Geckler (NM); Sharon Ma (NY); Guy Self (OH); Jeffrey Arnold (PA); Michael Bailes (SC); Shelley Wiseman (UT); Julie Fairbanks (VA); Marcia Violette (VT); and Theresa Miller (WV). Also participating was: Shane Quinlan (NC).

1. **Adopted its Nov. 12, 2020, Minutes**

Mr. Haworth said the Working Group met Nov. 12, 2020, and took the following action: 1) adopted its Oct. 22, 2020, minutes; 2) discussed the Market Conduct Annual Statement (MCAS) attestation process; and 3) discussed training opportunities for market regulation analysts.

Mr. Flott made a motion, seconded by Ms. Amann, to adopt the Working Group’s Nov. 12, 2020, minutes (see NAIC Proceedings – Fall 2020, Market Regulation and Consumer Affairs (D) Committee, Attachment Six). The motion passed unanimously.

2. **Discussed Revisions to the MCAS Best Practices Guide**

Ms. Rebholz said the group revising the MCAS Best Practices Guide is reviewing other MCAS documents to ensure that all the MCAS documents are consistent. The other documents to be reviewed are the frequently asked questions (FAQ) document, the MCAS Industry User Guide, and the data call letter. Ms. Rebholz said the work should be complete after two more meetings.

3. **Discussed MCAS 14-Day Extension Limitation**

Mr. Haworth said the review of the MCAS Best Practices Guide raised the concern of a consistent response to requests for extensions. He said the MCAS submission tool currently allows a company to choose up to 60 days. This creates inconsistencies when some states allow the entire 60 days, some allow 30 days, and others limit the request to two weeks. Mr. Haworth also noted that companies need to re-log into the MCAS to know how the jurisdictions responded to their request. He said it is possible that a company may assume all states are providing 60 days if they only see one or two of the responses.

Mr. Haworth said the group revising the MCAS Best Practices Guide is advising all jurisdictions to allow no more than 14-day extensions. The group is also asking that the MCAS tool be adjusted to only allow extensions for no more than 14 days at a time. Mr. Haworth noted that it is possible that companies may need more than the 14 days, so the MCAS tool will also need to be changed to allow companies to submit second or third requests for extensions. He said this will require some programming work by NAIC’s Information Technology Group (ITG). He said if the Working Group approves this change, the soonest it would be in effect would be for the 2021 data reported in 2022, but it might be the following year.

Mr. Flott said he supports a 14-day limit on extension, and he said the Kansas Department of Insurance (DOI) already has a standard of only 14 days. He said if additional time is needed, the company is required to provide more specifics to the request. He said the company will typically not contact the DOI if it fails to submit by the end of the extension. Mr. Arnold said he supports the 14-day limitation. Ms. Ailor said the Arizona DOI has the same concern with companies asking for extensions and still not submitting their MCAS by the end of the extension. She also said certain companies fail to even request an extension. She suggested editing the MCAS data call letter to advise that the company must make an extension request if it cannot submit its data by the due date. Mr. McKinley asked if a company can receive a reminder as the end of extension period nears. He also suggested that the MCAS system could advise the jurisdictions about the extensions that are outstanding with no submission. Mr. Dachs also supported the 14-day limitation.
Mr. Haworth said the Working Group will vote on this issue on the next conference call. He asked that comments be sent to Randy Helder (NAIC) by Feb. 17.

4. Discussed MCAS Attestation

Mr. Haworth said in November, the Working Group heard an industry request to allow for more attesters in the MCAS. Some companies that write multiple lines of business in multiple states have different individuals who can appropriately attest to the data. However, Mr. Haworth said the MCAS currently only allows for one attester per company to attest to the accuracy of the data regardless of the number of lines of business and states being reported in the MCAS. He said there seemed to be support from the Working Group on expanding the ability of companies to have more than one attester to the accuracy of the data. He said during the November meeting, he asked NAIC staff support to investigate possible solutions.

Teresa Cooper (NAIC) said the MCAS interrogatories can quickly be revised to add two lines for each attester. She does not believe this would be a substantive change and could be implemented right away. There would be two lines for the individual attesting to the accuracy and another two lines for the person attesting that the data that can be traced back to its source within the company. The four additional lines would be available for each line of business blank in each state. The first line would be for the name of the attester and the second line for the title of the attester. While the current comment section for the attestation would be lost, the comment boxes in the interrogatories can be used for the attestation. Ms. Cooper said if the attestation is currently not completed, the company is unable to submit its filings. She said validations would need to be added to require the new interrogatories to be completed before the filing can be submitted.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said she needs to speak with APCIA membership about this, but she does not believe there would be any concerns.

Joseph E. Zolecki (Blue Cross Blue Shield Association—BCBSA) asked if there would be a description and example provided. Ms. Cooper said she could draft a mock-up of the suggestion.

Birny Birnbaum (Center for Economic Justice—CEJ) said he agrees that the change is not substantive, but if companies believe they need time to re-program, a requirement could be put in place requiring a cover letter with the names of the attesters for each line of business and each state.

Mr. Haworth asked for comments to be sent to Mr. Helder by Feb. 17.

5. Discussed the Market Analysis Framework

Mr. Haworth said the subgroup revising the market analysis chapters of the Market Regulation Handbook has made progress and should be completed by the Spring National Meeting.

6. Discussed Market Analysis Training

Mr. Haworth said in the last Working Group meeting, there was clearly a strong desire to obtain additional training from both the NAIC and peers in other jurisdictions. He said the Working Group only received one response to its request for suggested training ideas and opportunities, and he once again asked for more comments by Feb. 17.

Ms. Phelps said she would appreciate training on the meaning and importance of the variety of different ratios used by market analysts. Ms. Amann said there is a how-to guide that was published by the NAIC that contained information on financial ratios and why they should be considered in market analysis. She said she has a hard copy, but it probably needs updates, even though the underlying concepts are still valuable.

Mr. Quinlan said the only MCAS training class for state insurance regulators is an on-site class in Kansas City that was cancelled in 2020. He asked if MCAS training can be made virtual. Mr. Helder noted that the training discussed at the Working Group should include a variety of delivery methods, including virtual and in-person.

7. Discussed Other Matters

Mr. Birnbaum said the initial premise of the MCAS was that the additional market conduct data obtained by annual reporting would increase the efficiency of analysts to identify and focus on priorities. This would also reduce the burden on companies...
because they would not have to respond to numerous ad hoc data calls and inquiries. However, Mr. Birnbaum noted that companies continually resist any additional lines of business or data elements in the MCAS. He said if the MCAS were meeting its initial goals, companies should be cooperative with adding additional lines and data elements. He asked why companies did not take the MCAS as seriously as they do other reporting requirements. He asked whether the MCAS is achieving its initial purpose, and the reason if it is not.

Mr. Zolecki asked if the Working Group has considered a possible extension of MCAS reporting, as was provided in 2020, since the COVID-19 pandemic is continuing. Mr. Haworth said it has not because, by now, companies and state insurance regulators have adapted to the new environment. He said extensions create delays in the market analysis process.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 23, 2021. The following Working Group members participated: Rebecca Rebholz, Chair (WI); Tate Flott, Vice Chair (KS); Crystal Phelps (AR); Sarah Borunda (AZ); Scott Woods (FL); Sarah Crittenden (GA); Erica Weyhenmeyer (IL); Dawna Kokosinski (MD); Jill Huiskens (MI); Teresa Kroll (MO); Martin Swanson (NE); Leatrice Geckler (NM); Guy Self (OH); Jeffrey Arnold (PA); Michael Bailes (SC); Maggie Dell (SD); Shelli Isiminger (TN); Tanji J. Northrup (UT); Lichiou Lee (WA); and Letha Tate (WV).

1. **Adopted its Feb. 24 Minutes**

   The Working Group met Feb. 24 and took the following action: 1) adopted its Nov. 16, 2020, minutes; 2) heard an update on the Travel Market Conduct Annual Statement (MCAS); 3) heard an update on the Other Health MCAS; 4) discussed a new MCAS proposal submission form; 5) discussed reporting of complaint and lawsuit data elements within the Home and Auto MCAS reporting blanks; 6) discussed the MCAS lawsuit definitions; and 7) discussed the addition of Accelerated Underwriting data elements to the Life MCAS and Digital Claims data elements to the Home and Auto MCAS lines of business.

   Mr. Flott made a motion, seconded by Ms. Kroll to adopt the Working Group’s Feb. 24 minutes (Attachment Four-A). The motion passed unanimously.

2. **Heard an Update on the Travel MCAS**

   Ms. Rebholz noted that the Travel MCAS subject matter expert (SME) group met March 3 and March 15. She stated that during those calls, Birny Birnbaum (Center for Economic Justice—CEJ) presented a draft blank for the SME group’s review. Discussions continued regarding the appropriate reporting granularity, and decisions were made on the granularity of specific data elements. The SME group is making good progress, and it will move to the definitions work in the next few sessions. Discussions will continue during the next Travel SME call, which is scheduled for March 29. Members of the SME group were advised to review the drafts posted to the Working Group’s web page in preparation for the call.

3. **Heard an Update on the Other Health MCAS**

   Randy Helder (NAIC) stated that the Other Health SME group is meeting on a weekly basis through the month of April and concentrating on short-term limited-duration (STLD) insurance products. He stated that the intention of the drafting group is to complete an STLD insurance blank and definitions before the end of April to allow for at least 30 days of exposure prior to a vote on the blank before June 1. He stated that as soon as the group completes the STLD insurance blanks and definitions, it will begin work on the remaining Other Health products. Currently, the group is on iteration 5.2, which is very close to what the final product will look like. This version and two prior versions are on the Working Group’s web page in the “Current MCAS Blanks Discussions” box. Mr. Helder stated that the drafting group’s next meeting would address producer commissions and the blank definitions.

4. **Heard an Update on the Accelerated Underwriting and Digital Claims Discussions**

   Ms. Rebholz stated that volunteers have agreed to participate in the Accelerated Underwriting and Digital Claims discussion groups. She stated that the first Accelerated Underwriting call is scheduled for March 24, and the first Digital Claims call is scheduled for April 1. Working Group members, interested state insurance regulators, and interested parties that would like to participate in these SME groups were asked to contact Teresa Cooper (NAIC). Leaders for these SME groups are also still needed, and they should contact Ms. Cooper if interested in leading these groups.

5. **Discussed the Placement of Complaint and Lawsuit Data Elements within the Home and Auto MCAS Reporting Blanks**

   Ms. Rebholz noted that Attachment Two in the meeting materials was also provided for the Feb. 24 meeting; it is a grid that summarizes the placement of the complaint and lawsuit data elements within each MCAS blank and whether the complaint and lawsuit data is reported at the line of business coverage level. She stated that the Home and Auto complaint data elements are...
currently reported within the underwriting section of the blank, and they are reported in total only. During its Feb. 24 call, the Working Group was asked to consider if this level of reporting is what state insurance regulators need to perform market analysis or if complaint data by coverage type is needed. Ms. Rebholz stated that all other MCAS lines of business that contain complaint data elements require reporting at the coverage type level. Mr. Birnbaum noted in February that separate coverage reporting of complaints makes sense for the Homeowners line of business, but it may be more difficult for the Private Passenger Auto line. Ms. Rebholz noted that the goal for this meeting is to get a couple of options for the Working Group to consider and then make a final decision during the April meeting. Mr. Self stated that he has not found the need to look for a higher level of detail than what is currently available in this complaint area; therefore, he suggested no change here. Ms. Rebholz stated that in the April Working Group meeting, no change here will be considered, but if anyone has additional thoughts on this matter, she suggested that they share them on the next call.

Ms. Rebholz stated that the lawsuit data elements for Home and Auto are reported by coverage type; using the current lawsuit definitions for the Home and Auto lines of business only captures lawsuit data for claim-related suits in the Home and Auto lines of business. During the February meeting, Peter Kochenburger (University of Connecticut School of Law) and Mr. Birnbaum encouraged the collection of data for lawsuits that are not related to claims. Mr. Birnbaum also encouraged consistency in the reporting of lawsuits within the MCAS lines of business. However, as with complaints, he noted that the reporting of lawsuit groups for auto coverage types may not make sense. Ms. Rebholz noted that there are similar issues to review regarding the Lender-Placed Insurance (LPI) Auto and Home line of business; LPI lawsuits are currently reported in the claims section, but the lawsuit definition for LPI is the same as for those MCAS lines where reporting is done in a separate reporting section. She noted that she would like to have some lawsuit reporting options that can be considered during the April meeting. The question for the Working Group to consider is whether only claims-related lawsuit data for the Home and Auto MCAS lines of business is needed or if lawsuit data should include suits not related to claims.

Ms. Rebholz stated that it appears the options are: 1) no change, which means data will continue being collected for only claims-related lawsuits; or 2) collecting data for lawsuits not just related to claims but also related to more broad categories for the insurance product, such as the application and sales processes. Mr. Flott stated that he supports option one, as the reviews he has done have not warranted a change here, but he also has no objections to option two if that information is necessary for others. Ms. Rebholz noted that a draft of these options will be written for consideration on the next Working Group call.

6. Discussed the MCAS Lawsuit Definitions

Ms. Rebholz stated that the Working Group needs to make determinations on the level of lawsuit reporting for Home, Auto and LPI before addressing the lawsuit definitions for those lines of business. However, at this time, the Working Group needs to review the lawsuit definition used for Life, Annuity, Disability Income, Private Flood and Long-Term Care (LTC) to determine if any revisions are needed. The definition was provided in Attachment Three of the meeting materials. Ms. Isiminger stated that in reading the definition of lawsuit and the second bullet listed, it states, “an action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant. For purposes of reporting lawsuits for (MCAS Line of Business) products: include all lawsuits, whether or not a hearing or proceeding before the court occurred.” She asked if this means any kind of filing whether it is the company doing it or the consumer. Lisa Brown (American Property Casualty Insurance Association—APCIA) stated that the first bullet states, “include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant,” and the way the first and second bullets are stated seems unclear. Ms. Rebholz stated that this would be a good time to review this information and add clarity where needed. Ms. Cooper stated that she will take notes on these comments so that edits to these bullets can be discussed further during the next Working Group meeting.

Mr. Kochenburger asked why information on arbitrations is not included, as bullet number three in the lawsuit definition states, “do not include arbitrations of any sort.” He stated that he understands that the results are confidential, but he believes knowing the number of arbitrations would be useful information for state insurance regulators. Ms. Brown stated that arbitration data is collected on the Auto and Homeowners lines of business. Richard L. Bates (State Farm Insurance) asked what the intent of including “agent as a defendant” in the first bullet discussed earlier is. He explained that it is possible that the insurance company may not be a party to the lawsuit or even know about it. Ms. Isiminger stated that she understands the term agent to mean a conservator or power of attorney. Ms. Brown stated that clarifying that producers are excluded could be helpful in this area. Ms. Rebholz stated that she would like to further review the use of the word “complainants” in bullet five versus potentially using the word “plaintiffs.” Mr. Bates asked for additional clarity on the last bullet, which states, “include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.” Ms. Isiminger suggested that the court case information could be cited here.
Mr. Bates stated that when looking at the lawsuit ratios that were developed for Auto and Homeowners, it compares it against claims closed without payment. He stated that if non-claims lawsuits are added in the aggregate, it could cause misrepresentation of information; he stated that the ratio could become less valuable. He asked that this be considered in the decisions going forward on whether to add lawsuits not related to claims. Ms. Rebholz stated that this would be considered if there were to be a change made on lawsuit data collected. There were no other concerns raised on the other bullet points in the lawsuit definition, and she stated that the concerns raised will be noted and discussed in further detail on the next call.

7. Discussed Other Matters

Ms. Rebholz stated that during the February meeting, a new MCAS proposal form was introduced to be used anytime a new change is proposed for an MCAS blank or data call and definitions. After introducing it, comments were received, and an updated version was posted to the Working Group’s web page. Any comments or questions regarding the new form should be sent to Ms. Rebholz, Mr. Flott or Ms. Cooper.

Ms. Rebholz stated that regarding the Disability Income MCAS, a question has come up that NAIC staff need guidance on. The issue is with the Schedule 3 reporting within the Disability Income blank. Schedule 3 is titled “Disability Income Claims Decisions Processed.” This title seems to indicate that all claim decisions, regardless of paid or declined, would be included in the schedule. However, the median day data elements 29 and 34 specifically say to include processing time for claims resulting in payment. Ms. Rebholz noted that Schedule 4 is titled “Disability Income Resulting in Closed Without Payment”; so, it includes only those decisions resulting in closed without payment. The question for the Working Group to consider is whether Schedule 3 should include all claim decisions or only those that result in payment.

Dianne Evans (UnitedHealthcare) stated that UnitedHealthcare uses Schedule 3 to report only claims that were paid. Ms. Rebholz stated that the solution could be adding a note or clarification within the data call and definitions on the blank itself, stating that Schedule 3 is intended to capture data only for claims processing times for those claims decisions that resulted in payment.

Mr. Flott made a motion, seconded by Mr. Self, to add a note in the Disability Income blank clarifying that Schedule 3 is designed to only collect claims information about claims that have payment. The motion passed unanimously.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Feb. 24, 2021. The following Working Group members participated: Rebecca Rebholz, Chair (WI); Tate Flott, Vice Chair (KS); Maria Ailor (AZ); Scott Woods (FL); Sarah Crittenden (GA); October Nickel (ID); Erica Weyhenmeyer (IL); Lori Cunningham (KY); Mary Lou Moran (MA); Erica Bailey (MD); Jill Huisken (MI); Teresa Kroll (MO); Martin Swanson (NE); Jeffrey Arnold and Katie Dzurec (PA); Michael Bailes and Rachel Moore (SC); Maggie Dell (SD); Shelli Isiminger (TN); and Letha Tate (WV).

1. **Adopted its Nov. 16, 2020, Minutes**

   The Working Group met Nov. 16, 2020, and took the following action: 1) adopted its Oct. 28, 2020, minutes; 2) discussed options for collections of transactional level data; 3) adopted the motion to revert the definition of lawsuit for the Home and Auto Market Conduct Annual Statement (MCAS) to the one used in the 2019 data year; and 4) adopted the motion to specify $50,000 in premiums written as the threshold in the 2021 Disability Income Data Call and Definitions document.

   Mr. Flott made a motion, seconded by Mr. Swanson, to adopt the Working Group’s Nov. 16, 2020, minutes (see NAIC Proceedings – Fall 2020, Market Regulation and Consumer Affairs (D) Committee, Attachment Seven). The motion passed unanimously.

2. **Heard an Update on the Travel MCAS**

   Ms. Rebholz noted that the Travel MCAS subject matter expert (SME) group met Jan. 26. She stated that the discussions have been moving forward at a nice pace, but they have been slowed down a bit by discussions related to the appropriate reporting granularity. Breaking the data out by retailer types such as airline, cruise line, websites, etc. was discussed. Discussions will continue during the next Travel SME call, which is scheduled for March 3 at 11:00 a.m. CT.

3. **Heard an Update on the Other Health MCAS**

   Ms. Dzurec stated that last year it was decided to break out two workstreams—one for Short-Term Limited-Duration (STLD) and the second for Other Health. The most recent version of the STLD blank was posted to the MCAS web page in December 2020 for further consideration. A lengthy discussion took place about whether to maintain summary level data in the STLD blank, and that is currently the path being pursued unless different direction is given by the Market Regulation and Consumer Affairs (D) Committee. The next step for the STLD blank is to finalize the definitions and use of terms in the document posted on the MCAS web page. Ms. Dzurec invited others to join the discussion and provide any thoughts or feedback on the document and definitions.

   Ms. Ailor asked if the goal is to get the STLD blank finalized and approved this year. Ms. Dzurec confirmed that it was, and she asked that any comments be provided by March 10. She stated that the next SME call for Other Health will be scheduled before the Spring National Meeting, likely in the second or third week of March. Ms. Ailor asked when final comments would need to be approved to be implemented next year. Teresa Cooper (NAIC) stated that approvals by the Working Group are needed by June 1 to be effective in the next data year, so having the information ready for the Working Group to review about one month before that would be best.

4. **Discussed a New MCAS Proposal Submission Form**

   Ms. Rebholz noted that a new MCAS proposal submission form will start being used to eliminate confusion and uncertainty surrounding proposed MCAS updates. The form is posted to the Working Group web page as a fillable Microsoft Word form, along with the instructions for completing the form. It can be found under the Related Documents tab of the web page. Suggestions for the MCAS blanks or data call and definitions can be proposed by completing this form. Ms. Rebholz noted that if there is a current proposal being discussed with anyone, NAIC staff will work with those parties to get the proposal put into the form.
5. Discussed the Reporting of Complaint and Lawsuit Data Elements within the Home and Auto MCAS Reporting Blanks

Ms. Rebholz noted that last year there was discussion regarding the placement of reporting of the complaint and lawsuit data elements within the Home and Auto MCAS reporting blanks, and no changes were made at that time. Attachment Three in the meeting materials is a grid that summarizes the placement of the complaint and lawsuit data elements within each MCAS blank and indicates whether the complaint and lawsuit data is reported at the line of business coverage level. Ms. Rebholz stated that no decisions will be made today, and this will be discussed again in the future. She stated that the focus for this call would be getting feedback on the Home and Auto complaints data, and these data elements are currently reported in the underwriting section as only a total number. The question for the Working Group to think about is if this level of reporting is what state insurance regulators need to perform market analysis or whether they want the complaint data broken out by coverage type. Ms. Rebholz stated that all other lines of business that contain complaint data elements require reporting at the coverage-type level.

Birny Birnbaum (Center for Economic Justice—CEJ) stated that having complaints reported separately for life insurance makes sense because the different coverages represent different products and policies, and for similar reasons, he also believes it makes sense to break out the reporting for Homeowners. He said it might be more difficult for Auto though since there can be multiple coverages within one policy; a company may have difficulty deciding which coverage to report a complaint for on pricing or claim settlement when it might affect a bodily injury claim, property claim, or uninsured motorist claim at the same time. Ms. Rebholz asked call participants to give this agenda item some thought before the next meeting so the Working Group can consider which direction to move in.

Ms. Rebholz stated that the Home and Auto lawsuit data elements are reported by coverage type. Using the current lawsuit definitions for the Home and Auto lines of business, lawsuit information is only collected for claims-related suits. The question for the Working Group to consider is whether state insurance regulators need only claims-related lawsuit data for the Home and Auto lines of business or whether the lawsuit data include suits that are not related to claims.

Peter Kochenburger (University of Connecticut School of Law) stated that he encourages the collection of data for suits not related to claims, as he feels that information would be equally as valuable and important. He stated that there is an increasing ability for anyone who is interested to get access to litigation data for free by going on state dockets for example, so the ability to have a better understanding of what lawsuits are out there and have a better understanding of those lawsuits would be helpful.

Mr. Birnbaum stated that there should be consistency with treatment of lawsuits across the various MCAS lines of business. He stated that the CEJ supports collecting information on all types of lawsuits such as underwriting, pricing and sales, in addition to claims. He stated that on the issue of collecting lawsuit data by coverage, if there are separate products that are clearly distinguishable products like life insurance, then it would make sense to collect it broken out by coverage. However, when separate products are not clearly distinguishable among the coverages like Auto, it would not make sense to ask for reporting lawsuits by coverage.

Lisa Brown (American Property Casualty Insurance Association—APCIA) stated that the lawsuits closed during the period with consideration for the consumer were added for both Home and Private Passenger Auto (PPA) last year, which is consistent across the other lines.

Ms. Rebholz asked the Working Group to give this topic additional thought and to be prepared for further discussion on this matter in the next meeting.

6. Discussed the MCAS Lawsuit Definitions

Ms. Rebholz stated that during the 2020 Fall National Meeting, the Market Regulation and Consumer Affairs (D) Committee approved reverting the 2021 Homeowners and PPA definition of lawsuit back to the definition used in the 2020 Data Call and Definitions. The Committee also approved updating the 2021 definitions of lawsuits closed during the period with consideration for the consumer by replacing the phrase “applicant, policyholder, or beneficiary” with the term “claimant.” Ms. Rebholz noted that the meeting materials include the 2021 data year definitions for lawsuit and lawsuits closed during the period with consideration for the consumer for each of the MCAS lines of business and some additional definitions regarding lawsuits contained in the Disability Income MCAS data call and definitions for comparison. She asked that the Working Group review the materials provided and give thoughts on the definitions and level of granularity needed for lawsuit reporting so that it can be discussed in more detail in the future.
7. **Discussed the Addition of Accelerated Underwriting Data Elements to the Life MCAS and Digital Claims Data Elements to the Home and Auto MCAS Lines**

Ms. Rebholz stated that last year, the Working Group agreed to move forward with reviewing the proposed definitions and data elements for both accelerated underwriting and digital claims, with the intent to implement reporting on those terms. Discussions on these topics need to be done at a more detailed level, so SME groups will be formed to continue these discussions. Once the SME groups reach consensus, the topics will be brought back to the Working Group for consideration. Ms. Rebholz asked that if anyone would like to be part of the SME groups for either accelerated underwriting or digital claims, they should send an email to Tressa Smith (NAIC) or Ms. Cooper, and they will collect the lists. Leaders for these SME groups will also be needed; anyone with interest should contact Ms. Smith or Ms. Cooper as well.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
The Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 30, 2021. The following Working Group members participated: Bruce R. Ramge, Chair, and Laura Arp, Martin Swanson and Reva Vandevoorde (NE); Mel Heaps, Teri Ann Mecca and Crystal Phelps (AR); Eleanor Coe and Damion Hughes (CO); Kurt Swan (CT); Sharon Shipp (DC); Susan Jennette and Frank Pyle (DE); Sarah Crittenden (GA); Lindsay Bates and Daniel Mathis (IA); Erica Weyhenmeyer (IL); Lori Cunningham and Ron Kreiter (KY); Mary Lou Moran (MA); Jill Huiskens (MI); Paul Hanson (MN) Jo LeDuc, Win Nickens and Rob Reichart (MO); Tracy Biehn and Teresa Knowles (NC); Maureen Belanger and Edwin Pugsley (NH); Ralph Boeckman (NJ); Leatrice Geckler (NM); Hermoliva Abejar, Barbara D. Richardson and Peggy Willard-Ross (NV); Sylvia Lawson, Sharon Ma and Elvis Soto (NY); Rodney Beech and Jana Jarrett (OH); Landon Hubbart (OK); Brian Fordham (OR); Gary Jones (PA); Thomas Morgan and Matthew Tarpley (TX); Julie Fairbanks and Bryan Wachter (VA); Mary Block, Isabelle Turpin Keiser and Christina Rouleau (VT); John Haworth and Jeanette Plitt (WA); Barbara Belling, Diane Dambach, Darcy Paskey, Rebecca Rebholz and Jody Ullman (WI); and Desiree Mauller (WV). Also participating was: Matt Gendron (RI).

1. **Heard Opening Remarks and Reviewed its 2021 Charges**

   Director Ramge welcomed returning Working Group members and a new member state, Texas, represented by Mr. Tarpley. Changes in Working Group member state representation in 2021 include Mr. Kreiter, Joel Bengo (NM) and Ms. Dambach.

   Director Ramge said the charges of this Working Group, as adopted by the Market Regulation and Consumer Affairs (D) Committee, are to:
   - Develop market conduct examination standards, as necessary, for inclusion in the *Market Regulation Handbook* (Handbook).
   - Monitor the adoption and revision of NAIC models and develop market conduct examination standards to correspond with adopted NAIC models.
   - Develop updated standardized data requests (SDRs), as necessary, for inclusion in the Handbook.
   - Develop uniform market conduct procedural guidance (e.g., a library, depository or warehouse with market conduct examination templates, such as an exam call letter, exam exit agenda, etc.) for inclusion in, or for use in conjunction with, the Handbook.
   - Coordinate with the Innovation and Technology (EX) Task Force to develop market conduct examiner guidance for the oversight of regulated entities’ use of insurance and non-insurance consumer data and models using algorithms and artificial intelligence (AI).
   - Discuss the effectiveness of a group’s supervision of market conduct risks and develop examination procedural guidance, as necessary.
   - Discuss the role of market conduct examiners in reviewing insurers’ corporate governance, as outlined in the *Corporate Governance Annual Disclosure Model Act* (#305) and the *Corporate Governance Annual Disclosure Model Regulation* (#306).

2. **Discussed its Potential 2021 Tasks**

   Director Ramge said the Working Group is the successor Working Group to the Market Conduct Examination Standards (D) Working Group. The Working Group will not meet at NAIC national meetings; it will accomplish its assigned tasks via regularly scheduled conference calls, to occur approximately every four to six weeks.

   Regarding its adopted 2021 charges, the Working Group identified recently adopted NAIC models for which examination standards/state insurance regulator guidance may need to be updated in the Handbook. Some of the models include: 1) the *Suitability in Annuity Transactions Model Regulation* (#275) and the frequently asked questions (FAQ) document that the Annuity Suitability (A) Working Group is developing, when that document is ultimately adopted by the NAIC; 2) the *Insurance Holding Company System Regulatory Act* (#440); 3) the *Health Maintenance Organization Model Act* (#430); 4) the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651); and 5) the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805). Director Ramge indicated that he had prepared an initial
comprehensive draft of updated examination standards to address Model #275 for the Working Group to use as a starting point as it moves forward with its work this year to develop corresponding exam standards for that model.

Director Ramge asked for state insurance regulators to contact Petra Wallace (NAIC) to indicate their interest in volunteering to: 1) review any of the models on the list of recently adopted models—i.e., Model #275, Model #430, Model #440, Model #651 and Model #805; 2) report to the Working Group regarding whether the Handbook should be updated in these subject areas; and 3) to work together as regulator-only subject matter expert (SME) groups to prepare an initial draft for review and discussion by the Working Group.

Director Ramge made additional suggestions for the Working Group to consider, which include: 1) the Regulatory Framework (B) Task Force’s recent adoption of the new Pharmacy Benefit Manager Licensure and Regulation Model Act on March 18; 2) the amendments to the Unfair Trade Practices Act (#880) regarding rebating practices, which are currently being considered by the Innovation and Technology (EX) Task Force; 3) coordination with the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, since one of its charges is to “provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC Market Regulation Handbook”; 4) monitoring the Long-Term Care Insurance Model Update (B) Subgroup, which plans in 2021 to update the Long-Term Care Insurance Model Act (#640), the Long-Term Care Insurance Model Regulation (#641), the Limited Long Term Care Insurance Model Act (#642), and the Limited Long Term Care Insurance Model Regulation (#643); 5) the issues being discussed at the Big Data and Artificial Intelligence (EX) Working Group surrounding the regulated entity use of AI in underwriting, claims, marketing and rating (as model laws/regulations are developed to address AI, there should be corresponding changes made to the Handbook); 6) the work that the Accelerated Underwriting (A) Working Group will be doing in 2021; and 7) the federal No Surprises Act whenever the regulations have been finalized at the federal level.

Birny Birnbaum (Center for Economic Justice—CEJ) suggested that the Working Group consider making corresponding revisions to the Handbook regarding the Real Property Lender-Placed Insurance Model Act, which was adopted by the Property and Casualty Insurance (C) Committee in December 2020 and will be considered for adoption by the Executive (EX) Committee and Plenary at the Spring National Meeting.

3. Discussed New Draft Title SDRs for Inclusion in the Reference Documents of the Market Regulation Handbook

Director Ramge said title insurance related SDRs addressing in force policies and claims were developed by state insurance regulator SMEs for the Working Group’s review, discussion and consideration of adoption for inclusion as new SDRs in the reference documents of the Handbook. The title insurance SDRs, which were circulated to the Working Group, interested state insurance regulators, and interested parties on March 23, replace the title SDRs that were adopted by the NAIC in 2008. Director Ramge said the SMEs had developed the SDRs under the leadership of Mr. Reichart.

Mr. Reichart said the new title SDRs have substantial changes and updates compared to the existing 2008 title SDRs, which were very basic. Mr. Birnbaum suggested that data fields be added to the title claims SDR to address regulated entity use of arbitration provisions. Ronald J. Blitenthal (Old Republic National Title Insurance Company) said some data fields in the SDRs do not apply to title insurance (e.g., the use of “NPN,” “agent first name,” “agent middle name,” “agent last name,” and “CSR”). He said a lot of the information requested in the title SDR exposure drafts may not be collected by regulated entities, and if it would need to be collected, software that is used by the industry would need to be updated.

Director Ramge said just because a data field is on an SDR does not mean it is a new requirement of regulated entities; an SDR is a list of suggested fields for state departments of insurance (DOIs) to consider when requesting data from regulated entities. Ms. Plitt agreed, saying that the fields on an SDR are not a mandate, and not each and every data field needs to be used or run in each and every SDR. Mr. Hanson said the fields on an SDR are not a mandate, but regulated entities need to be aware of the data. He added that the data fields contained in an SDR is an issue that a state DOI works out with a regulated entity’s exam coordinator; a state DOI adds fields to an SDR where it feels it is appropriate, and this occurs not only with title SDRs, but also with SDRs related to other lines of business.

Mr. Gendron said all title producers in Rhode Island are licensed with the Insurance Division of the State of Rhode Island Department of Business Regulation. He also indicated that per the information that he recently received from the Rhode Island Producer Licensing Division, while not every state/jurisdiction uses the NPN for title agents, most states do use the National Producer Number (NPN) number as a unique identifier.
Mr. Blitenthal said he would be submitting comments on behalf of the Old Republic National Title Insurance Company, and he mentioned that the American Land Title Association (ALTA) would likely also be submitting comments on the title SDR exposure drafts.

Director Ramge said the comment due date on the new draft title SDRs is April 23.

4. Discussed Other Matters

Director Ramge asked the Working Group members to participate in as many Working Group conference calls as possible this year so the Working Group can accomplish the tasks that are planned in 2021.

Director Ramge said NAIC staff will provide advance email notice of the next Working Group conference call, which is anticipated to occur in April.

With regard to Director Ramge’s retirement from the Nebraska DOI on April 9, Ms. LeDuc thanked Director Ramge for his leadership of the Working Group and his contributions to market regulation uniformity. Ms. Wallace added that Director Ramge has been chair of the Working Group’s predecessor group, the Market Conduct Examination Standards (D) Working Group since 2008, and substantial improvements to the Handbook and NAIC market conduct regulatory guidance have occurred under his leadership.

Having no further business, the Market Conduct Examination Guidelines (D) Working Group adjourned.
The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 29, 2021. The following Working Group members participated: Cynthia Amann, Chair (MO); Ron Kreiter, Vice Chair (KY); Erica Weyhenmeyer (IL); LeAnn Crow (KS); T.J. Patton (MN); Chris Aufenthie and Johnny Palsgraaf (ND); Martin Swanson (NE); Raven Collins and Brian Fordham (OR); and Don Beatty and Katie Johnson (VA).

1. **Adopted its 2020 Fall National Meeting Minutes**

Mr. Kreiter made a motion, seconded by Mr. Aufenthie, to adopt the Working Group’s Nov. 20 minutes (see NAIC Proceedings – Fall 2020, Market Regulation and Consumer Affairs (D) Committee, Attachment Nine). The motion passed unanimously.

2. **Received Status Reports on Federal and State Privacy Legislation**

Brooke Stringer (NAIC) said both Republicans and Democrats acknowledge the need for federal data privacy legislation, but the differences in their approach have thwarted efforts to enact comprehensive legislation thus far. She said the key points of contention include: 1) whether, and to what extent, federal legislation should preempt state laws; and 2) whether the legislation should include a private right of action. Ms. Stringer said as momentum builds among the states to enact data privacy laws, so does the pressure on Congress to act at the federal level. She said both sides of the aisle were engaged over the past session of Congress on developing privacy bills and were committed to comprehensive legislation, but the onset of the pandemic stalled out their momentum.

Ms. Stringer said the most likely starting points for federal legislation in 2021 are: 1) U.S. Senate Commerce Committee Chairwoman Maria Cantwell’s (D-WA) Consumer Online Privacy Rights Act (COPRA), which contained strict standards, but would have established a preemptive floor and allowed for a private right of action; and 2) Senate Commerce Committee Ranking Member Roger Wicker’s (R-MS) SAFE DATA Act, which also had high standards and would have preempted all state data privacy and security laws. However, Ms. Stringer said it also had a federal Gramm-Leach-Bliley Act (GLBA) carve out, which may have protected some of the state consumer data privacy laws. While these two bills differ, Ms. Stringer said both senators remain interested in a bipartisan Senate bill.

She said the House Energy and Commerce Committee developed a bipartisan staff draft bill during the last Congress that would have provided the Federal Trade Commission (FTC) with significant rule-making authority to implement standards, but the committee had not yet determined how to handle preemption. Ms. Stringer said U.S. Rep. Suzan Delbene (D-WA) recently reintroduced the Information Transparency and Personal Data Control Act (H.R.1816), which would create a unified national data privacy standard and preempt conflicting state laws. She said according to Rep. Delbene’s press release, this act would allow consumers to opt-in before companies could use the consumer’s most sensitive, private information in ways consumers might not expect. Ms. Stringer said the Act increases transparency by requiring companies to disclose: 1) the purpose of sharing personal information; 2) if personal information will be shared; and 3) with whom the personal information will be shared.

Ms. Stringer said NAIC staff continue to engage with Congress, oppose preemptive legislative proposals and inform Congress of the NAIC’s Privacy Protections (D) Working Group’s efforts to update NAIC models. She said the NAIC continues to underscore the importance of not disregarding the existing state regulatory framework or inhibiting ongoing efforts in the states to develop laws and regulations in the best interest of insurance consumers. Birny Birnbaum (Center for Economic Justice—CEJ) asked if the NAIC had entered a position with Congress on the privacy of consumer data for insurance purposes. Ms. Stringer said this has been communicated via the staff level only at this time, but not in a formal letter to this Congress.

Jennifer Neuerburg (NAIC) provided a recap of what happened with state privacy legislation in 2020: 1) at least 30 states introduced data privacy legislation—many of them comprehensive and similar to the California Consumer Privacy Act (CCPA)—but very few of them were enacted since COVID-19 disrupted everyone’s legislative sessions; 2) California residents voted in November 2020 to approve the California Consumer Privacy Rights Act (CPRA), which modified the CCPA, further expanded consumer privacy rights, and created a statewide privacy agency that will be charged with enforcing privacy laws and will likely lead to increased enforcement actions for privacy violations in California; 3) California also extended its exemption from the CCPA to certain employment information and personal information involved in business-to-business
communications and transactions; 4) Michigan modified requirements for insurers providing privacy policies to customers; and
5) Virginia enacted a law governing driver’s license scanning.

Ms. Neuerburg said there has been a lot of activity in state privacy legislation in 2021. She said privacy bills have been
Neuerburg said these bills focus on business obligations stemming from consumer rights but vary in substance. She said many
of these bills indicate to which businesses the bill applies. For example, Florida’s bill applies to for-profit businesses in the
state that: 1) have global annual gross revenues in excess of $25 million; 2) annually buy, sell or share for commercial purposes
the personal information of 50,000 or more consumers; or 3) derive 50% or more of its global revenues from selling or sharing
personal information.

Ms. Neuerburg said no template is emerging yet; however, she said some have the following issues in common: 1) they have a
requirement that covered entities perform a risk assessment; 2) they provide for a private right of action; 3) they address data
security, as well as data privacy; 4) they resemble the General Data Protection Regulation (GDPR) and would be more
expansive than the CCPA. Arizona, Florida and Washington are examples of states with such legislation; and 4) they exempt
data collected in compliance with the GLBA, as well as entities subject to the GLBA. Colorado and Virginia, for example,
have this exemption. She said these exemptions differ from the CCPA and CPRA, which only exclude the data collected in
compliance with the GLBA, while still regulating the entity.

Ms. Neuerburg said the CCPA was amended just this month to make it easier for consumers to opt-out. She said most recently,
Virginia passed its Consumer Data Protection Act, which creates consumer rights like the CCPA; imposes security and
assessment requirements for businesses; and leaves enforcement entirely up to the attorney general, so there is no private right
of action. Ms. Neuerburg said a lot more movement in state legislation is anticipated throughout 2021. Ms. Amann said a lot
of legislation being considered this year lumps together data security and data privacy, but this Working Group will continue
to focus its efforts on the privacy of insurance-related consumer data.

3. **Reviewed the 2021 NAIC Member-Adopted Strategy for Consumer Data Privacy Protections**

Ms. Amann said since the Working Group completed its work plan in 2020, the Working Group received additional guidance
through the Market Regulation and Consumer Affairs (D) Committee in the form of the following NAIC Member-Adopted
Strategy for Consumer Data Privacy Protections (Attachment D). She said the Working Group is currently working on item C
because item A and item B have already been completed.

**NAIC Member-Adopted Strategy for Consumer Data Privacy Protections**

1. Charge the Market Regulation and Consumer Affairs (D) Committee with:
   a. Summarizing consumer data privacy protections found in existing NAIC models—the Health Information Privacy
      Model Act (#55), the NAIC Insurance Information and Privacy Protection Model Act (#670), and the Privacy of
      Consumer Financial and Health Information Regulation (#672).
   b. Identifying notice requirements of states, the European Union’s (EU’s) General Data Protection Regulation (GDPR)
      and the California Consumer Privacy Act (CCPA), and how insurers may be subject to these requirements.
   c. Identifying corresponding consumer rights that attach to notice requirements, such as the right to opt-out of data
      sharing, the right to correct or delete information, the right of data portability and the right to restrict the use of data,
      and how insurers may be subject to these requirements.
   d. Setting forth a policy statement on the minimum consumer data privacy protections that are appropriate for the
      business of insurance.
   e. Delivering a report on items (a–d) above by the NAIC Fall National Meeting.

2. Engage with state attorneys general (AGs), Congress and federal regulatory agencies on state and federal data privacy
   laws to minimize preemption provisions and maximize state insurance regulatory authority.

3. Reappoint the Privacy Protections (D) Working Group to revise NAIC models, as necessary, to incorporate minimum
   consumer data privacy protections that are appropriate for the business of insurance. Complete by the NAIC Fall National
   Meeting.

4. **Discussed Comments Received on the 2020 Fall National Meeting Verbal Gap Analysis**

Robert Neill (American Council of Life Insurers—ACLI) said he and Shelby Schoensee (ACLI) would be sharing trade
opinions on behalf of ACLI members since the retirement of Robbie Meyer (ACLI). He said the ACLI was concerned with the
Working Group’s strategy being too challenging and that the timeline was too short for the Working Group to accomplish its
objectives by the Fall National Meeting. Mr. Neill suggested that the Working Group would be better served to wait to see where federal and state legislation ended up regarding preemption, which seemed to cover business areas broader than insurance. He also said that the business of insurance would be uniquely affected by general data privacy concerns due to conflicting and overlapping provisions. Ms. Amann said the Working Group would attempt to simplify its discussions surrounding overlapping and conflicting legislation by focusing on actual practices rather than on theory. She said the Working Group would call on trades to assist in this important endeavor.

Chris Petersen (Arbor Strategies LLC), speaking on behalf of the Coalition of Health Insurers, said that health insurance is already subject to the GDPR and CCPA, even though these are not insurance-specific. He said insurance products should be regulated by insurance commissioners and should include a safe harbor for compliant companies. Mr. Petersen said a two-stage approach is encouraged for gap analysis: 1) gaps in NAIC models should be identified; and 2) it should be determined whether gaps need to be filled. For example, he said that portability is not needed in insurance because an employer (not the employee) decides what data is needed for employees while they are employed, but this data is no longer needed after the employee leaves the company. Mr. Petersen said this type of data cannot be purged from employers’ systems as the GDPR wants. Ms. Amann said the Working Group welcomes all kinds of input because insurance is unique from technology companies, vendors, data brokers, third parties, etc.

Cate Paulino (National Association of Mutual Insurance Companies—NAMIC) said clarification and workability should be goals of the Working Group. She said notices are covered by Model #672, and if it is revised, she asked that it also: 1) incorporates a safe harbor; 2) has more examples added to Appendix A; 3) continues to allow federal privacy notices to be used; and 4) allows web postings with other alternatives.

Ms. Paulino said the frequency of notices should be revisited because it has changed in that the annual notices required starting in 2016 by the GLBA are no longer required if there have been no changes by the company since the prior notice. She said workability is the concern regarding the opt-out versus opt-in data-sharing question, so the insurance industry, other than health insurance, urges the Working Group to continue to use opt-out for continuity of existing practices. Ms. Paulino said there is no real difference in them, except opt-in is a lot more difficult for companies to administer, and the scope of opt-out works much better with business function exemptions such as fraud, liens, underwriting, etc. Ms. Amann said state insurance regulators are ready to learn more about areas of functionality from trades.

Angela Gleason (American Property Casualty Insurance Companies—APCIA) said privacy regulation is not new to insurance, but there is a difference between theory and practice. She said that she appreciates the Working Group not rushing into changes without first considering the risk, uncertainty and conflicts such changes may cause. Ms. Gleason said notices are working well now, have changed over time, and can adapt again given the proper time and consideration. She said the concern with portability is that currently states have the right to regulate insurance in their states and that states should continue to have that right in the future.

Ms. Gleason said that partnership and collaboration is needed between industry and state insurance regulators. She said the timeline is challenging and asked if it might be more flexible. She also asked if other committees would be making decisions regarding consumer data privacy together or separately.

Ms. Amann said the Working Group process would not be slowed down, but it would be thorough. She asked that additional comments on strategy be sent to her, Mr. Kreiter or Lois E. Alexander (NAIC). Ms. Amann said all comments together will help the Working Group maintain its focus on consumer protections, not coverage inhibitors. She said all NAIC groups working on issues related to consumer data protection would work in tandem and collaboration with one another throughout the year.

Mr. Birnbaum said consumer protections and data privacy have more in common than not and that differences are the exception rather than the rule. He asked why the Working Group did not hear from consumer representatives about data protection gaps. Mr. Birnbaum said the Working Group should reach out to them to get a broader set of perspectives. Ms. Amann said all state insurance regulators and interested parties are always welcome to submit comments to the Working Group at any time.

5. **Announced the Consumer Privacy Protections Panel at the NAIC Virtual Insurance Summit**

Ms. Amann said there will be a panel on consumer privacy protections at the NAIC virtual Insurance Summit June 21–24, with herself, Mr. Kreiter, Ms. Stringer, Ms. Neuerburg and two NAIC consumer representatives serving as panelists.

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Ms. Amann said Ms. Alexander would be sending an email regarding the schedule of meetings every four to six weeks with a road map designed to avoid overlap with other groups working on interrelated issues.

Having no further business, the Privacy Protections (D) Working Group adjourned.
The Antifraud (D) Task Force met March 24, 2021. The following Task Force members participated: Trinidad Navarro, Chair (DE); Judith L. French, Vice Chair, represented by Michelle Brugh Rafeld (OH); Lori K. Wing-Heier represented by Alex Romero (AK); Alan McClain represented by Crystal Phelps, Pat O’Kelly and Teri Ann Mecca (AR); Evan G. Daniels represented by Paul Hill (AZ); Ricardo Lara represented by George Mueller (CA); Michael Conway represented by Damion Hughes (CO); David M. Mais represented by Kurt Swan (CT); Karima M. Woods represented by Brian Bressman (DC); Vicki Schmidt represented by Ryan Morton (KS); Sharon P. Clark represented by Juan Garrett (KY); James J. Donelon represented by Matthew Stewart (LA); Kathleen A. Burren represented by Steve Wright (MD); Anita G. Fox represented Jill Huisken, Lee McCallister and Randall Gregg (MI); Grace Arnold represented by Michael Marben (MN); Chlora Lindley-Myers represented by Carrie Couch and Marjorie Thompson (MO); Mike Chaney represented by John Hornback (MS); Troy Downing and Jeannie Keller (MT); Mike Causey represented by Angela Hatchell and Della Shepherd and Tracy Biehn (NC); Jon Godfread represented by Dale Pittman (ND); Bruce R. Range represented by Martin Swanson (NE); Chris Nicoloopulos represented by Brendan Harrles (NH); Marlene Caride represented by Richard Besser (NJ); Russel Toal represented by Devin Chapman (NM); Barbara D. Richardson represented by Stephanie McGee (NV); Glen Mulready represented by Rick Wagnon (OK); Andrew R Stolfi represented by Stephanie Noren (OR); Raymond G. Farmer represented by Chuck Myers and Michael Bailes (SC); Doug Slape represented by Chris Davis (TX); Jonathan T. Pike represented by Armand Glick (UT); Scott A. White represented by Mike Beavers (VA); and James A. Dodrill and Greg Elam (WV).

1. **Adopted its 2020 Fall National Meeting Minutes**

   Mr. Stewart made a motion, seconded by Mr. Mueller to adopt the Task Force’s Nov. 16, 2020 (see NAIC Proceedings – Fall 2020, Antifraud (D) Task Force) minutes. The motion passed unanimously.

2. **Reviewed its 2021 Charges**

   Commissioner Navarro said that the Task Force’s 2021 charges did not change much from 2020 and that the focus remains the same, with its continued fight against insurance fraud. Commissioner Navarro said as the Task Force moves forward this year, it is important to note that aside from its charges, it will continue to focus on insurance fraud generated from COVID-19. He said the Task Force has held separate meetings and set time aside during previous national meetings to specifically discuss and receive updates on potential fraud resulting from COVID-19. Commissioner Navarro said in addition to these meetings, the Task Force members have participated in monthly regulator-only meetings concerning the improper marketing of health plans arising out of the COVID-19 pandemic. Commissioner Navarro advised that the Task Force will continue to monitor fraudulent activity and meet as necessary in an effort to bring public awareness.

3. **Received an Update from the Antifraud Technology (D) Working Group**

   Mr. Glick said the Working Group has not met this year. However, he said it is continuing to work on its new charge given to it in 2020: “Review and provide recommendations for the development of an Antifraud Plan repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions.” Mr. Glick said the Working Group determined that to complete this charge, it first needed to review and revise the 2011 Antifraud Plan Guideline (#1690). He said by the end of 2020, the Working Group finalized this review, and it was adopted by the Market Regulation and Consumer Affairs (D) Committee during the 2020 Fall National Meeting. Mr. Glick said that the revisions will be presented to the Executive (EX) Committee and Plenary for full adoption at the 2021 Spring National Meeting. Mr. Glick said once fully adopted, the Working Group’s next step will be to work on creating a guideline template that can be used for the creation and submission of an Antifraud Fraud Plan. He said this template will also be used for developing the repository. Mr. Glick said the Working Group will meet with NAIC staff to determine whether this project will need to be presented to the NAIC budget process or if it can be completed without additional budgetary resources.

   Mr. Glick said the Working Group has been responsible for monitoring the Online Fraud Reporting System (OFRS) for enhancements. Mr. Glick said due to the OFRS Redesign Project being completed internally, the Working Group has suspended its enhancement review. He said the Working Group remains involved in the redesign process and as the project moves closer to being completed, it will report back to the Task Force.
4. Received an Update from the Antifraud Education Enhancement (D) Working Group

Greg Welker (NAIC) said the Working Group hosted a webinar on Feb. 11, 2021, presented by CARCO on the mobile capabilities it can provide state insurance departments to assist with fighting insurance fraud. He said the Working Group also will host an investigator safety training webinar on June 2, 2021, from 12:00 – 1:30 p.m. CT.

5. Received an Update on the OFRS

Mr. Welker said in 2018, the NAIC approved the redesign of the OFRS. He said the purpose of the redesign was to modernize interfaces for state insurance regulator, public and industry users. The redesign changes would support a new functionality for the system while also providing the means to create a series of reports that would provide states with detailed data that could be used for tracking fraud trends. Mr. Welker said there is an industry and consumer side to the OFRS. NAIC staff have focused on completing the industry side first. Once completed, it can be used to mirror the changes for the consumer. Mr. Welker said this process is nearing completion, and a beta environment is being finalized. The expectation is to have that beta testing available in April. Mr. Welker said it is important for states and all other users to recognize that during the redesign process, the functionality of the OFRS has not been interrupted and that states are still receiving the fraud referral data. He said NAIC staff will continue to collaborate with the Working Group through the completion of the redesign.

6. Heard a Report from the Coalition

Matthew Smith (Coalition Against Insurance Fraud—Coalition) said the Coalition has been working heavily on its research studies. Mr. Smith said its recent survey in these studies concerns COVID-19. Mr. Smith said an email was sent to all state fraud directors in September 2020 to track insurance fraud taking place due to the COVID-19 pandemic. Mr. Smith said the survey has recently been sent out again for the two different sets of data to be used as comparison. Mr. Smith said the data indicates that there has been an increase in arson.

Mr. Smith said the Coalition is conducting a joint research study with IBM and Lux Off to track the globalization of insurance products. He said the goal is to get this study out in November. Mr. Smith said another study concerning technology will be used to track how states are using technology, the advantages and disadvantages of technology, and what the future brings.

Mr. Smith said the Coalition has been tracking 83 separate pieces of legislation across the U.S. He said five states have enacted new laws that are now on the books, and one bill in Idaho concerning the assignment of benefits died in the Senate. Mr. Smith said this leaves 77 bills that are still pending across the U.S. Mr. Smith said the Coalition maintains a map on its website showing the pending bills. He said a majority of the bills filed across the U.S. deal with public adjusters. Mr. Smith said there are also workers’ compensation reforms, with five separate bills pending. He said the Coalition has also been tracking efforts being done concerning storm chasers, roofing and other contractors regarding natural disasters.

Mr. Smith said the Coalition has passed its counterfeit airbag legislation to protect consumers from counterfeit airbags. He said states are working together to push this legislation through. Mr. Smith said this has become more of an interest in states, and he expects for them to have an interest later this year. Mr. Smith said between the Coalition, the American Trucking Association (ATA) and the American Property and Casualty Insurers Association (APCIA), they will continue to work together to assist with the counterfeit airbag legislation in other states.

Mr. Smith said the Coalition is also monitoring staged automobile accidents and said that more reports are starting to show up. Mr. Smith said he encourages any states noticing an uptick in this area to reach out to the Coalition. He said another fraudulent activity that is being pushed concerns juvenile life insurance cases. He said this type of insurance fraud is being seen more throughout the U.S. He said the Coalition is working with states and legislation to create better regulation to cover these type of issues. Mr. Smith said they have also been monitoring sober issues and may be coming to the Task Force in the future for assistance with fighting these issues.

Mr. Smith said the Coalition has been working on its webinar program. On March 17, the Coalition hosted a webinar called “Building the Bridge,” which focused on consumers, government officials and insurers regarding the fight against insurance fraud. Mr. Smith said the Coalition will continue to host more webinars throughout the rest of the year. He said in addition to its webinar program, the Coalition also released a new infographic last week concerning the use of cell phones to expose individuals to fraud. Mr. Smith said there is a new Journal of Insurance Fraud article that was published by the Coalition concerning the dark core of white-collar crimes. He said the Coalition Legal Affairs Committee is working on state immunity laws and immunity reporting. The Coalition has updated its compendium of immunity provisions across the U.S.
Mr. Smith said lastly, the June mid-year meeting will be virtual, and the goal is to hold the end of year annual meeting in person Dec. 6–7 in Washington, DC.

7. **Heard a Report from the NICB**

Alan Haskins (National Insurance Crime Bureau—NICB) said in January, NICB released a slip and fall report as a proactive effort to increase awareness of these types of scams. Mr. Haskins said that NICB analyzed slip and fall questions that were claim data reported to it from 2017–2019. Mr. Haskins said with the review of California, Florida, New York, Pennsylvania and Texas, it was found that slip and fall claims were up 30%, with the impact on commercial insurance policies. Mr. Haskins said concerning personal property homeowner policies, there was a 39% increase between 2017–2019. He said NICB also issued a preliminary analysis that shows auto theft took a dramatic upward trend in 2020 compared to 2019, reversing a two-year decline in vehicle insurance fraud. Mr. Haskins said that due to the COVID-19 pandemic, NICB expects to see the vehicle insurance fraud trend continue to increase. He said the NICB is also seeing an uptick in juvenile vehicle theft.

Mr. Haskins said legislative sessions are halfway through in most states, and there has some successful passing of legislative language concerning insurance fraud. He said NICB is tackling more than 600 bills. In Idaho and Kentucky, there is legislation for funding for state fire marshals, towing and storage legislation. North Dakota has a new law providing civil fines against people committing insurance fraud. Additionally, a new law in Utah would restrict the access to vehicle accident reports. Mr. Haskins said NICB has supported legislation that would address funding and resources for state fraud dues dedicated to insurance fraud prosecutors and funding for auto prevention authorities with the uptick in vehicle insurance fraud.

Mr. Haskins said NICB will be hosting a 2021 Virtual Fraud Investigations Academy April 27–May 6. Mr. Haskins said a new publication called the *NICB Informer* is aimed at providing insurance industry executives with participatory intelligence to help identity risk and emerging threats to the insurance industry. He said this article edition will focus on the alarming increase in vehicle crimes.

8. **Discussed Other Matters**

Commissioner Navarro said the NAIC/NIPR Insurance Summit will take place during June and September this year. Commissioner Navarro said the dates are still being finalized. However, he said the plan will be to hold virtual session in June and then have hybrid sessions in September.

Having no further business, the Antifraud (D) Task Force adjourned.
MARKET INFORMATION SYSTEMS (D) TASK FORCE

Market Information Systems (D) Task Force March 22, 2021, Minutes ..............................................................9-60
Market Information Systems (MIS) Data Analysis and Recommendations (Attachment One) ..............................9-63
Market Information Systems (D) Task Force
Virtual Meeting (in lieu of meeting at the 2021 Spring National Meeting)
March 22, 2021

The Market Information Systems (D) Task Force met March 22, 2021. The following Task Force members participated: Mike Kreidler, Chair (WA); Chlora Lindley-Myers, Vice Chair (MO); Evan G. Daniels represented by Maria Ailor (AZ); Ricardo Lara represented by Pam O’Connell (CA); Michael Conway represented by Damion Hughes (CO); Andrew M. Mais represented by Kurt Swan (CT); Trinidad Navarro represented by Frank Pyle (DE); Dana Popish Severinghaus represented by Erica Weyhenmeyer (IL); Vickie Schmidt represented by Tate Flott (KS); James J. Donelon represented by Jeff Zewe (LA); Troy Downing represented by Jeannie Keller (MT); Marlene Caride represented by Ralph Boeckman (NJ); Barbara D. Richardson represented by Nick Stosis (NV); Judith L. French represented by Rodney Beetch (OH); Glen Mulready represented by Landon Hubbard (OK); Doug Slape represented by Rachel Cloyd (TX); Michael S. Pieciak represented by Isabelle Turpin Keiser (VT); and James A. Dodrill represented by Jeannie Tincher (WV). Also participating was: Brent Kabler (MO).

1. **Adopted its Nov. 17, 2020, Minutes**

   Director Lindley-Myers made a motion, seconded by Mr. Flott, to adopt the Task Force’s Nov. 17, 2020 minutes (see NAIC Proceedings – Fall 2020, Market Information Systems (D) Task Force). The motion passed unanimously.

2. **Discussed the Task Force’s 2021 Charges**

   Commissioner Kreidler said the Task Force’s 2021 charges remain consistent with its charges from last year. He said the Task Force will continue to ensure that the market information systems (MIS) support the strategic goals set by the Market Regulation and Consumer Affairs (D) Committee. The Task Force will do this by analyzing the quality of the data reported into the MIS, making recommendations for improving data quality, and providing guidance on the appropriate use of the MIS and data.

   Commissioner Kreidler said the Task Force has one Working Group, the Market Information Systems Research and Development (D) Working Group, reporting to the Task Force. It is chaired by Mr. Kabler. Commissioner Kreidler said the Task Force relies on the members of the Working Group to review and prioritize the Uniform System Enhancement Requests (USER) forms, which are sent to the Working Group by interested state insurance regulators to request changes to the MIS. He said the Working Group is also responsible for the yearly MIS metrics report, which measures the timeliness, accuracy and completeness of data reported into the MIS.

   Commissioner Kreidler said the Task Force is moving the charge to “develop recommendations for the incorporation of artificial intelligence (AI) abilities in the MIS for use in market analysis” to the Working Group. He said the charge is moving to the Working Group for two reasons. First, the Working Group has members with expertise in this field. Second, the Working Group meets more frequently and can devote more time to the charge. Commissioner Kreidler said the Task Force will still be responsible for the final product, and the Working Group will undertake this charge in open meetings.


   Mr. Kabler said the Working Group met March 19, 2021, and Dec. 2, 2020, in regulator-to-regulator session. During these meetings the Working Group reviewed and adopted the MIS metric report and recommendations for metric updates and methods to improve metric result reporting and data quality.

   Mr. Kabler said the Working Group also reviewed a new process for prioritizing USER forms. Ginny Ewing (NAIC) noted that the new process moves from a waterfall process to the lean, agile process used by NAIC Information Services. She said it is more transparent regarding what is in the backlog.

   Mr. Kabler said the Working Group also adopted proposed changes to the Regulatory Information Retrieval System (RIRS) coding structure. He said the proposal was reviewed with representatives of the Financial Analysis Solvency Tools (E) Working Group and the state producer licensing directors. He noted that modifications were made to the proposal based on their feedback. He said the proposal was also reviewed with the state back-office system vendors, who made a recommendation to create a user’s guide providing guidance for how the new codes should be used. He noted that based on the current available information, the vendors do not anticipate an additional cost to implement the necessary system changes to support the proposal.
Mr. Kabler said the RIRS coding change and re-structure has been the most ambitious project of the Market Information Systems Research and Development (D) Working Group. He has been working on it even before the Working Group was formed.

Mr. Kabler said the Working Group also considered the charge to “develop recommendations for the incorporation of artificial intelligence (AI) abilities in the MIS for use in market analysis.” He said he has some concerns because the term “artificial intelligence” is nebulous and defined in different, often contradictory, ways. He said the Working Group’s first task will be to develop a working definition for AI. He encouraged interested parties and interested state insurance regulators to participate in the discussions. He also said the Working Group was concerned that there is not enough market data to make AI feasible for market analysis. However, he noted that the Working Group is approaching the charge with an open mind and willingness to learn.

Birny Birnbaum (Center for Economic Justice—CEJ) asked why the proposed RIRS coding changes did not include all lines of business that are included in the financial annual statement. As an example, he noted that there were no line of business codes for lender-placed insurance. He noted that the definition of each proposed RIRS line of business states that it corresponds to the financial annual statement, so it would be expected that all financial lines of business should be included. Mr. Kabler said if additional lines of business are needed, he would not be averse to adding them. He said they may not have been included because there was not much market conduct concern in the missing lines of business.

Mr. Birnbaum asked for clarification of the meaning of the “Origin of Action” code statuses “keep” and “delete.” Mr. Kabler said codes with a code status of “delete” would be removed from the RIRS as an option.

Mr. Birnbaum said there were many codes in the “Reasons for Action” that were mutually exclusive; yet, the RIRS will allow multiple reasons per action. He asked if that would compromise the integrity of the data. Mr. Kabler said the nature of regulatory actions is that they often have multiple concerns and reasons. He said an examination is a single record within the RIRS, and the system must be able to capture all the reasons for a regulatory action.

Commissioner Kreidler said when adopting the Working Group’s report, the Task Force will also be adopting the changes to the USER form process, but it will not be adopting the proposed RIRS changes. He said the proposed RIRS change will be posted on the Task Force web page, and they will be considered for adoption at the Summer National Meeting.

Director Lindley-Myers made a motion, seconded by Mr. Flott, to adopt the Market Information Systems Research and Development (D) Working Group report. The motion passed unanimously.

4. **Adopted the MIS Data Analysis Metrics and Recommendations**

Commissioner Kreidler said review of the market data analysis metrics and recommendations began at the 2020 Fall National Meeting, but the report was not ready for adoption. He said the report is attached to the materials, and it is ready for adoption.

Director Lindley-Myers made a motion, seconded by Mr. Flott, to adopt the MIS data analysis and recommendations (Attachment One). The motion passed unanimously.

5. **Heard a Report on Outstanding USER Forms**

Ms. Ewing said the following USER forms are in development or complete:

- USER Form 10051 is a request to implement the Market Actions Tracking Systems (MATS) Web Service in State Based Systems (SBS). Ms. Ewing said this project is in progress. She said prototype and design decisions are being made.

- USER Form 10053 is a request to review RIRS codes to clarify definitions for consistent usage and make recommendations for revisions. Ms. Ewing said the coding changes were shared with financial and producer licensing regulators, and their input has been incorporated. She said the Working Group adopted the RIRS changes.

- USER Form 10080 is the request to update the RIRS to display data retention policies and terminology related to action dates. She said much of this request is complete, but the RIRS subject matter experts (SMEs) are reviewing the data dictionary and considering the issue of the “earliest action date” being misleading in the Regulatory Systems Participating State Report.
• USER Form 10082 is the request to add a Complaints Database System (CDS) subject code for “pandemic” and a coverage code for “business interruption.” She said while completing this request, it was discovered that subject codes are not displayed. She said a USER form will be created to correct this issue.

Ms. Ailor said USER Form 10069B was to add codes for pet insurance and lender-placed insurance. She said the pet insurance codes were implemented but not the lender-placed insurance codes. Ms. Ewing said the codes were supposed to have all been completed. She will check on the status and have them implemented.

Having no further business, the Market Information Systems (D) Task Force adjourned.

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Objective
It is essential that the systems on which insurance consumers and state insurance regulators depend use reliable data. These systems include, but are not limited to, the Consumer Insurance Search (CIS), Market Analysis Prioritization Tool (MAPT), Market Analysis Profile (MAP) and Market Analysis Review System (MARS). In addition to these National Association of Insurance Commissioners (NAIC) systems, many state systems and processes use NAIC Market Information System (MIS) data. Therefore, MIS data quality is critical.

The MIS data analysis metrics were developed at the direction of the Market Information Systems (D) Task Force to identify potential data quality issues in the NAIC MIS database. For each system, three aspects of data quality are considered: 1) completeness; 2) timeliness; and 3) accuracy.

Results
Note: These symbols indicate the following changes between periods: (▲) trending in positive direction; (▼) no change or unable to determine trend; and (▼) trending in negative direction.

Recommendation:
1. To ensure greater awareness of these results, distribute the jurisdiction level results to the Market Analysis Chiefs and request that they review and if necessary, seek resolution to data quality issues.

Complaint Database System (CDS)
Completeness:
C1. Identify errors that prevented submitted complaints from successfully loading to the NAIC MIS database.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Complaints Submitted</th>
<th>Complaints Not Loaded First Time</th>
<th>Complaints Not Loaded</th>
<th>Complaints Loaded</th>
<th>Errors Created</th>
<th>% Errors to Total Complaints Submitted</th>
<th>% Complaints Not Loaded to Total Complaints Submitted</th>
<th>△</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019*</td>
<td>367,880</td>
<td>93,518</td>
<td>22,926</td>
<td>344,954</td>
<td>112,725</td>
<td>30.64%</td>
<td>6.23%</td>
<td>▼</td>
</tr>
</tbody>
</table>

* A new load process was implemented in Q3 2017, which changed data captured regarding errors. For 2019, 'Number of Complaints Not Loaded' were included in the results. Therefore, trending information to prior years is unavailable.

Recommendation:
1. To bring more visibility to jurisdictions not participating in CDS, add completeness metric:
   C2. Identify jurisdictions that did not submit closed complaints in the prior year.

Timeliness:
T1. Identify jurisdictions that did not submit closed complaints to the NAIC MIS database at least monthly.

<table>
<thead>
<tr>
<th>Year</th>
<th># Jurisdictions That Did Not Submit Closed Complaints At Least Monthly</th>
<th># Jurisdictions That Did Submit Closed Complaints At Least Monthly</th>
<th>% Jurisdictions That Did Not Submit Closed Complaints At Least Monthly</th>
<th>△</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>9</td>
<td>47</td>
<td>16.07%</td>
<td>▼</td>
</tr>
<tr>
<td>2018*</td>
<td>6</td>
<td>50</td>
<td>10.71%</td>
<td>▼</td>
</tr>
</tbody>
</table>
### CDS T1
#### Trending Results
As of 10/13/2020

<table>
<thead>
<tr>
<th>Year</th>
<th># Jurisdictions That Did Not Submit Closed Complaints At Least Monthly</th>
<th># Jurisdictions That Did Submit Closed Complaints At Least Monthly</th>
<th>% Jurisdictions That Did Not Submit Closed Complaints At Least Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017*</td>
<td>9</td>
<td>47</td>
<td>16.07%</td>
</tr>
<tr>
<td>2016</td>
<td>13</td>
<td>43</td>
<td>23.21%</td>
</tr>
<tr>
<td>2015</td>
<td>18</td>
<td>38</td>
<td>32.14%</td>
</tr>
<tr>
<td>2014</td>
<td>18</td>
<td>38</td>
<td>32.14%</td>
</tr>
</tbody>
</table>

* With the introduction of a new load process, 2017 (Aug – Dec) and 2018 (May – Dec) results represent partial year data.

### CDS T2
#### Trending Results
As of 10/13/2020

<table>
<thead>
<tr>
<th>Year</th>
<th># Jurisdictions That Did Not Submit a Current Complaint At Least Monthly</th>
<th># Jurisdictions That Did Submit a Current Complaint At Least Monthly</th>
<th>% Jurisdictions That Did Not Submit a Current Complaint At Least Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>20</td>
<td>36</td>
<td>35.71%</td>
</tr>
</tbody>
</table>

### Accuracy:
A1. Identify complaints submitted with a confirmed indicator and only a disposition of “Complaint Withdrawn,” “No Action Requested/Required,” “Question of Fact/Contract Provision/Legal Issue,” “Company Position Substantiated,” “No Jurisdiction” or “Insufficient Information.”

### CDS A1
#### Trending Results
As of 6/11/2020

<table>
<thead>
<tr>
<th>Year</th>
<th>Complaint Withdrawn (Code 1312)</th>
<th>No Action Requested/Required (Code 1235)</th>
<th>Question of Fact/Contract Provision/Legal Issue (Code 1290)</th>
<th>Company Position Substantiated (Code 1285)</th>
<th>No Jurisdiction (Code 1300)</th>
<th>Insufficient Information (Code 1305)</th>
<th>Total</th>
<th>Total Number of All Complaints</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>53</td>
<td>672</td>
<td>646</td>
<td>1,544</td>
<td>119</td>
<td>88</td>
<td>3,122</td>
<td>224,846</td>
<td>1.39%</td>
</tr>
<tr>
<td>2018</td>
<td>46</td>
<td>916</td>
<td>1,043</td>
<td>2,086</td>
<td>249</td>
<td>145</td>
<td>4,485</td>
<td>233,562</td>
<td>1.92%</td>
</tr>
<tr>
<td>2017</td>
<td>304</td>
<td>1,427</td>
<td>2,038</td>
<td>11,471</td>
<td>1,014</td>
<td>214</td>
<td>16,486</td>
<td>232,764</td>
<td>7.07%</td>
</tr>
<tr>
<td>2016</td>
<td>359</td>
<td>2,884</td>
<td>2,070</td>
<td>11,763</td>
<td>1,315</td>
<td>248</td>
<td>18,639</td>
<td>255,000</td>
<td>7.31%</td>
</tr>
</tbody>
</table>

### Recommendation:
1. To more accurately reflect the results of this metric, present the number of distinct complaints that meet the criteria, rather than the results by disposition code.
A2. Identify complaints submitted for lines of business on companies that have no premium written for those lines of business on the financial annual statement.

<table>
<thead>
<tr>
<th>Year</th>
<th># Complaints with No State Level Premium</th>
<th># Complaints with No National Level Premium</th>
<th>Total Number of Complaints</th>
<th>% No State Level Premium Complaints to Total Complaints</th>
<th>% No National Level Premium Complaints to Total Complaints</th>
<th>△</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>11,541</td>
<td>7,656</td>
<td>224,822</td>
<td>5.13%</td>
<td>3.41%</td>
<td>△</td>
</tr>
<tr>
<td>2018</td>
<td>10,484</td>
<td>6,240</td>
<td>233,562</td>
<td>4.49%</td>
<td>2.67%</td>
<td>△</td>
</tr>
<tr>
<td>2017</td>
<td>10,430</td>
<td>5,429</td>
<td>232,764</td>
<td>4.48%</td>
<td>2.33%</td>
<td>△</td>
</tr>
<tr>
<td>2016</td>
<td>11,919</td>
<td>6,964</td>
<td>255,000</td>
<td>4.67%</td>
<td>2.73%</td>
<td>△</td>
</tr>
<tr>
<td>2015</td>
<td>10,273</td>
<td>5,816</td>
<td>240,443</td>
<td>4.27%</td>
<td>2.42%</td>
<td>→</td>
</tr>
</tbody>
</table>

Recommendation:
1. Review the CDS coverage type mapping to the financial annual statement line of business premiums for potential updates.

Market Action Tracking System (MATS)

Completeness:
C1. Compare number of “Closed” exams and entities in exams with the reported completed exams and entities in the NAIC’s corresponding year’s Insurance Department Resources Report (IDRR).

<table>
<thead>
<tr>
<th>Year</th>
<th>Exams Closed in MATS</th>
<th>Closed Exams Reported in IDRR</th>
<th>Difference</th>
<th>Entities in Exams Closed in MATS</th>
<th>Entities in Exams Closed in IDRR</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>382</td>
<td>511</td>
<td>-129 △</td>
<td>461</td>
<td>3,749</td>
<td>-3,288</td>
</tr>
<tr>
<td>2018</td>
<td>477</td>
<td>598</td>
<td>-121 △</td>
<td>616</td>
<td>641</td>
<td>-25</td>
</tr>
<tr>
<td>2017</td>
<td>525</td>
<td>544</td>
<td>-19 △</td>
<td>604</td>
<td>920</td>
<td>-316</td>
</tr>
<tr>
<td>2016</td>
<td>565</td>
<td>585</td>
<td>-20 △</td>
<td>670</td>
<td>827</td>
<td>-157</td>
</tr>
<tr>
<td>2015</td>
<td>590</td>
<td>880</td>
<td>-290 △</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2014</td>
<td>490</td>
<td>771</td>
<td>-281 △</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2013</td>
<td>667</td>
<td>806</td>
<td>-139   →</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Recommendations:
1. Investigate reasons for discrepancies between MATS and the IDRR.
2. To make trending from year to year more meaningful, add a relative percentage to the results.
C2. Compare number of entities included in “Closed” actions with the reported entities included in market actions including Focused Inquiries and Non-Exam Regulatory Interventions in the IDRR.

<table>
<thead>
<tr>
<th>Year</th>
<th>Entities in Market Actions Closed in MATS</th>
<th>Entities in Market Actions Closed in IDRR</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>617</td>
<td>1,703</td>
<td>-1,086</td>
</tr>
<tr>
<td>2018</td>
<td>784</td>
<td>2,197</td>
<td>-1,413</td>
</tr>
<tr>
<td>2017</td>
<td>834</td>
<td>2,705</td>
<td>-1,871</td>
</tr>
</tbody>
</table>

Recommendations:
1. Investigate reasons for discrepancies between MATS and the IDRR.
2. To make trending from year to year more meaningful, add a relative percentage to the results.

C3. Identify records in the Regulatory Information Retrieval System (RIRS) with an origin code of “Market Conduct Exam” that do not have a corresponding record in MATS.

<table>
<thead>
<tr>
<th>Year</th>
<th>RIRS Actions with ‘Market Conduct Exam’ Origin with MATS</th>
<th>RIRS Actions with ‘Market Conduct Exam’ Origin without MATS</th>
<th>% RIRS Actions without MATS to RIRS Actions with ‘Market Conduct Exam’ Origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>243</td>
<td>8</td>
<td>96.71%</td>
</tr>
<tr>
<td>2018</td>
<td>195</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2017</td>
<td>168</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Timeliness:

Recommendations:
1. Provide education and training on an overview of MATS to insurance department staff, particularly those responsible for entering and maintaining MATS data.
2. NAIC staff outreach to MATS users to determine if updates are needed and assist, as necessary.

T2. Identify actions with an estimated start date that has passed more than 30 days ago, and the status is “Called Not Begun.”

<table>
<thead>
<tr>
<th>Year</th>
<th># Actions in ‘Called Not Begun’ Status with Estimated Start Date Passed the Following # Days</th>
<th>Actions in ‘Called Not Begun’ Status w/Estimated Start Date &gt; 30 Days</th>
<th>% Actions in ‘Called Not Begun’ w/ Estimated Start &gt; 30 Days to Total ‘Called Not Begun’</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>84</td>
<td>167</td>
<td>88.54%</td>
</tr>
<tr>
<td>2018</td>
<td>195</td>
<td>56</td>
<td>56.95%</td>
</tr>
</tbody>
</table>
T3. Identify actions with a status of “In Settlement” for more than 180 days.

<table>
<thead>
<tr>
<th>Year</th>
<th>0-180 Days</th>
<th>181-365 Days</th>
<th>366-730 Days</th>
<th>730+ Days</th>
<th>Total Actions in ‘In Settlement’ Status</th>
<th>Actions in ‘In Settlement’ Status &gt; 180 Days</th>
<th>% Actions in ‘In Settlement’ &gt; 180 Days to Total ‘In Settlement’</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>49</td>
<td>13</td>
<td>2</td>
<td>11</td>
<td>75</td>
<td>26</td>
<td>34.67%</td>
</tr>
<tr>
<td>2018</td>
<td>44</td>
<td>2</td>
<td>1</td>
<td>10</td>
<td>57</td>
<td>13</td>
<td>22.81%</td>
</tr>
</tbody>
</table>

T4. Identify actions with a status of “In Progress” for more than 18 months.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>747</td>
<td>105</td>
<td>243</td>
<td>60</td>
<td>1155</td>
<td>408</td>
<td>35.32%</td>
</tr>
<tr>
<td>2018</td>
<td>871</td>
<td>92</td>
<td>101</td>
<td>43</td>
<td>1107</td>
<td>236</td>
<td>21.32%</td>
</tr>
</tbody>
</table>

T5. Identify actions with a status of “Work Concluded” for more than 120 days.

<table>
<thead>
<tr>
<th>Year</th>
<th>0-120 Days</th>
<th>121-365 Days</th>
<th>366-730 Days</th>
<th>730+ Days</th>
<th>Total Actions in ‘Work Concluded’ Status</th>
<th>Actions in ‘Work Concluded’ Status &gt; 120 Days</th>
<th>% Actions in ‘Work Concluded’ &gt; 120 Days to Total ‘Work Concluded’</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>47</td>
<td>35</td>
<td>36</td>
<td>32</td>
<td>150</td>
<td>103</td>
<td>68.67%</td>
</tr>
<tr>
<td>2018</td>
<td>73</td>
<td>13</td>
<td>25</td>
<td>6</td>
<td>117</td>
<td>44</td>
<td>37.61%</td>
</tr>
</tbody>
</table>

T6. Identify actions with a status of “Anticipated” for more than 120 days.

<table>
<thead>
<tr>
<th>Year</th>
<th>0-120 Days</th>
<th>121-365 Days</th>
<th>366-730 Days</th>
<th>730+ Days</th>
<th>Total Actions in ‘Anticipated’ Status</th>
<th>Actions in ‘Anticipated’ Status &gt; 120 Days</th>
<th>% Actions in ‘Anticipated’ &gt; 120 Days to Total ‘Anticipated’</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>32</td>
<td>15</td>
<td>23</td>
<td>33</td>
<td>103</td>
<td>71</td>
<td>68.93%</td>
</tr>
<tr>
<td>2018</td>
<td>16</td>
<td>15</td>
<td>23</td>
<td>28</td>
<td>82</td>
<td>66</td>
<td>80.49%</td>
</tr>
</tbody>
</table>
T7. Identify actions with a status of "Suspended" for more than 120 days.

<table>
<thead>
<tr>
<th>Year</th>
<th>0-120 Days</th>
<th>121-365 Days</th>
<th>366-730 Days</th>
<th>730+ Days</th>
<th>Total Actions in 'Suspended' Status</th>
<th>Actions in 'Suspended' Status &gt; 120 Days</th>
<th>% Actions in 'Suspended' &gt; 120 Days to Total 'Suspended'</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>6</td>
<td>14</td>
<td>3</td>
<td>160</td>
<td>183</td>
<td>177</td>
<td>96.72%</td>
</tr>
<tr>
<td>2018</td>
<td>6</td>
<td>6</td>
<td>40</td>
<td>129</td>
<td>181</td>
<td>175</td>
<td>96.89%</td>
</tr>
</tbody>
</table>

Accuracy:
Note: No metrics have been defined to measure MATS data accuracy.

Market Analysis Review System (MARS)

Completeness:
C1. Identify jurisdictions that did complete the minimum threshold that year.

<table>
<thead>
<tr>
<th>Year</th>
<th>Minimum Threshold</th>
<th># Jurisdictions That Did Not Complete Minimum Threshold</th>
<th>% Jurisdictions That Did Not Complete Minimum Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>20 Reviews</td>
<td>30</td>
<td>53.57%</td>
</tr>
<tr>
<td>2018</td>
<td>15 Reviews</td>
<td>26</td>
<td>46.43%</td>
</tr>
<tr>
<td>2017</td>
<td>10 Reviews</td>
<td>19</td>
<td>33.93%</td>
</tr>
<tr>
<td>2016</td>
<td>1 Level One Review</td>
<td>7</td>
<td>12.50%</td>
</tr>
<tr>
<td>2015</td>
<td>1 Level One Review</td>
<td>9</td>
<td>16.07%</td>
</tr>
<tr>
<td>2014</td>
<td>1 Level One Review</td>
<td>10</td>
<td>17.86%</td>
</tr>
</tbody>
</table>

Timeliness:
T2. Compare data year to review year for the past year.

<table>
<thead>
<tr>
<th>Year</th>
<th>Current Data Year</th>
<th>Not Current Data Year</th>
<th>Total Reviews</th>
<th>% Current Data Year to Total Reviews</th>
<th>% Not Current Data Year to Total Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>1,551</td>
<td>296</td>
<td>1,847</td>
<td>83.97%</td>
<td>16.03%</td>
</tr>
<tr>
<td>2018</td>
<td>1,511</td>
<td>57</td>
<td>1,568</td>
<td>96.36%</td>
<td>3.64%</td>
</tr>
<tr>
<td>2017</td>
<td>1,533</td>
<td>99</td>
<td>1,632</td>
<td>93.93%</td>
<td>6.07%</td>
</tr>
<tr>
<td>2016</td>
<td>1,928</td>
<td>57</td>
<td>1,985</td>
<td>97.13%</td>
<td>2.87%</td>
</tr>
<tr>
<td>2015</td>
<td>1,785</td>
<td>56</td>
<td>1,841</td>
<td>96.96%</td>
<td>3.04%</td>
</tr>
<tr>
<td>2014</td>
<td>1,900</td>
<td>39</td>
<td>1,939</td>
<td>97.99%</td>
<td>2.01%</td>
</tr>
</tbody>
</table>

Recommendations:
1. To better reflect the intent of the metric, rename T2 to 'Identify reviews that did not use the most current financial annual statement data year. Note: the most current financial data year is 45 days after the filing deadline.

2. To reflect use of the Market Conduct Annual Statement data, add timeliness metric:
   T3. Identify reviews that did not use the most current Market Conduct Annual Statement data year. Note: the most current MCAS data year is 60 days after the filing deadline.
Accuracy:
Note: No metrics have been defined to measure MARS data accuracy.

Market Conduct Annual Statement (MCAS)
Completeness:
C1. Identify non-participating jurisdictions.

<table>
<thead>
<tr>
<th>Data Year</th>
<th># of Non-participating Jurisdictions</th>
<th>% Non-participating Jurisdictions</th>
<th>Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>7</td>
<td>12.50%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>7</td>
<td>12.50%</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>7</td>
<td>12.50%</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>7</td>
<td>12.50%</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>9</td>
<td>16.07%</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>9</td>
<td>16.07%</td>
<td></td>
</tr>
</tbody>
</table>

Recommendation:
1. Reach out to the non-participating jurisdictions to raise awareness of MCAS and determine interest in participating.

C2. Identify missing company filings for current MCAS data year.

<table>
<thead>
<tr>
<th>Data Year</th>
<th>Total Required to File</th>
<th>Missing Filings</th>
<th>% of Missing Filings to Total Required to File</th>
<th>Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019*</td>
<td>34,594</td>
<td>262</td>
<td>0.76%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>31,331</td>
<td>121</td>
<td>0.39%</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>31,599</td>
<td>130</td>
<td>0.41%</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>29,645</td>
<td>81</td>
<td>0.27%</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>28,881</td>
<td>97</td>
<td>0.34%</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>26,927</td>
<td>78</td>
<td>0.27%</td>
<td></td>
</tr>
</tbody>
</table>

* The 2019 data year results will likely change significantly as additional filings due 8/31 (Health and Disability Income) are received and processed.

C3. Identify companies that were required to file, requested a waiver, and the jurisdiction did not respond.

<table>
<thead>
<tr>
<th>Data Year</th>
<th>Waivers Approved</th>
<th>Waivers Denied</th>
<th>Waivers Pending</th>
<th>Total Waivers Requested</th>
<th>% Approved to Total Requested</th>
<th>% Denied to Total Requested</th>
<th>% Pending to Total Requested</th>
<th>Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>617</td>
<td>16</td>
<td>38</td>
<td>671</td>
<td>91.95%</td>
<td>2.38%</td>
<td>5.66%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>550</td>
<td>20</td>
<td>39</td>
<td>609</td>
<td>90.31%</td>
<td>3.28%</td>
<td>6.40%</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>600</td>
<td>88</td>
<td>58</td>
<td>746</td>
<td>80.43%</td>
<td>11.80%</td>
<td>7.77%</td>
<td></td>
</tr>
</tbody>
</table>

Recommendations:
1. Create a new PICS event that notifies subscribers of pending waiver and extension requests each week.
2. Provide regulator training on the MCAS waiver and extension process.
Timeliness:
T1. Identify filings submitted 45 days after deadline for the current MCAS data year.

<table>
<thead>
<tr>
<th>Data Year</th>
<th>Total Required to File</th>
<th>Filed 45+ Days Late</th>
<th>% of 45+ Days Late Filings to Total Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019*</td>
<td>35,190</td>
<td>36</td>
<td>0.10%</td>
</tr>
<tr>
<td>2018</td>
<td>31,948</td>
<td>46</td>
<td>0.14%</td>
</tr>
<tr>
<td>2017</td>
<td>31,599</td>
<td>261</td>
<td>0.83%</td>
</tr>
<tr>
<td>2016</td>
<td>29,645</td>
<td>7</td>
<td>0.02%</td>
</tr>
<tr>
<td>2015</td>
<td>28,881</td>
<td>50</td>
<td>0.17%</td>
</tr>
<tr>
<td>2014</td>
<td>28,927</td>
<td>34</td>
<td>0.12%</td>
</tr>
</tbody>
</table>

* The 2019 data year results will likely change significantly as additional filings due 8/31 (Health and Disability Income) are received and processed.

T2. Identify companies that were required to file, requested an extension, and the jurisdiction did not respond.

<table>
<thead>
<tr>
<th>Data Year</th>
<th>Extensions Approved</th>
<th>Extensions Denied</th>
<th>Extensions Pending</th>
<th>Total Extensions</th>
<th>% Approved to Total Requested</th>
<th>% Denied to Total Requested</th>
<th>% Pending to Total Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>1,262</td>
<td>173</td>
<td>110</td>
<td>1,545</td>
<td>81.68%</td>
<td>11.20%</td>
<td>7.12%</td>
</tr>
<tr>
<td>2018</td>
<td>1,468</td>
<td>63</td>
<td>150</td>
<td>1,681</td>
<td>87.33%</td>
<td>3.75%</td>
<td>8.92%</td>
</tr>
<tr>
<td>2017</td>
<td>1,740</td>
<td>44</td>
<td>189</td>
<td>1,973</td>
<td>88.19%</td>
<td>2.23%</td>
<td>9.58%</td>
</tr>
</tbody>
</table>

Accuracy:
A1. Review validation exceptions for the current MCAS data year.

<table>
<thead>
<tr>
<th>Data Year</th>
<th>Validation Exceptions on Original Filings</th>
<th>Current Unresolved Exceptions</th>
<th>Total Validations Run</th>
<th>Original Filing Exceptions/ Total Validations Run</th>
<th>Current Unresolved Exceptions/ Total Validations Run</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019*</td>
<td>39,080</td>
<td>149</td>
<td>4,619,035</td>
<td>.85%</td>
<td>0.00%</td>
</tr>
<tr>
<td>2018</td>
<td>22,216</td>
<td>53</td>
<td>2,911,446</td>
<td>.76%</td>
<td>0.00%</td>
</tr>
<tr>
<td>2017</td>
<td>19,958</td>
<td>2,386</td>
<td>2,677,924</td>
<td>.75%</td>
<td>0.09%</td>
</tr>
<tr>
<td>2016</td>
<td>17,626</td>
<td>252</td>
<td>1,719,728</td>
<td>1.02%</td>
<td>0.01%</td>
</tr>
<tr>
<td>2015</td>
<td>13,562</td>
<td>0</td>
<td>1,069,681</td>
<td>1.27%</td>
<td>0.00%</td>
</tr>
<tr>
<td>2014</td>
<td>14,413</td>
<td>640</td>
<td>1,021,478</td>
<td>1.41%</td>
<td>0.06%</td>
</tr>
</tbody>
</table>

* The 2019 data year results will likely change significantly as additional filings due 8/31 (Health and Disability Income) are received and processed.
A2. Identify refilings.

<table>
<thead>
<tr>
<th>Data Year</th>
<th>Amended Filings or Refilings</th>
<th>Total Filings</th>
<th>% Amended Filings or Refilings to Total Filings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019 *</td>
<td>4,535</td>
<td>40,566</td>
<td>11.18%</td>
</tr>
<tr>
<td>2018</td>
<td>5,488</td>
<td>38,607</td>
<td>14.22%</td>
</tr>
<tr>
<td>2017</td>
<td>4,325</td>
<td>36,749</td>
<td>11.77%</td>
</tr>
<tr>
<td>2016</td>
<td>5,608</td>
<td>36,676</td>
<td>15.29%</td>
</tr>
<tr>
<td>2015</td>
<td>4,063</td>
<td>34,130</td>
<td>11.90%</td>
</tr>
<tr>
<td>2014</td>
<td>3,543</td>
<td>33,761</td>
<td>10.49%</td>
</tr>
</tbody>
</table>

* The 2019 data year results will likely change significantly as additional filings due 8/31 (Health and Disability income) are received and processed.

Regulatory Information Retrieval System (RIRS)

Completeness:

C1. Identify jurisdictions that have not submitted actions in the past year.

<table>
<thead>
<tr>
<th>Year</th>
<th># Jurisdictions That Did Not Submit Actions</th>
<th>% Jurisdictions That Did Not Submit Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>5</td>
<td>8.93%</td>
</tr>
<tr>
<td>2018</td>
<td>7</td>
<td>12.50%</td>
</tr>
<tr>
<td>2017</td>
<td>7</td>
<td>12.50%</td>
</tr>
<tr>
<td>2016</td>
<td>7</td>
<td>12.50%</td>
</tr>
<tr>
<td>2015</td>
<td>7</td>
<td>12.50%</td>
</tr>
<tr>
<td>2014</td>
<td>7</td>
<td>12.50%</td>
</tr>
</tbody>
</table>

C2. Identify errors that prevented submitted regulatory actions from successfully loading to the NAIC MIS database.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Actions Submitted</th>
<th>Actions Not Loaded First Time</th>
<th>Actions Not Loaded</th>
<th>Actions Loaded</th>
<th>Errors Created</th>
<th>% Errors Created to Total Actions Submitted</th>
<th>% Actions Not Loaded to Total Actions Submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019*</td>
<td>14,726</td>
<td>3,220</td>
<td>2,614</td>
<td>12,112</td>
<td>4,757</td>
<td>32.30%</td>
<td>17.75%</td>
</tr>
</tbody>
</table>

* A new load process was implemented in Q3 2017, which changed data captured regarding errors. For 2019, ‘Number of Complaints Not Loaded’ were included in the results. Therefore, trending information to prior years is unavailable.
Timeliness:
T1. Identify regulatory actions with a date of entry 90 days after the effective date.

<table>
<thead>
<tr>
<th>Year</th>
<th>Actions Entered Within 90 Days of Effective Date</th>
<th>Actions Entered 91 Days or Later than Effective Date</th>
<th>Total Actions Effective and Entered</th>
<th>% Actions Entered Within 90 Days of Effective Date to Total Actions</th>
<th>% of Actions Entered 91 Days or Later than Effective Date to Total Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>7,049</td>
<td>547</td>
<td>7,596</td>
<td>92.80%</td>
<td>7.20%</td>
</tr>
<tr>
<td>2018</td>
<td>7,380</td>
<td>406</td>
<td>7,786</td>
<td>94.79%</td>
<td>5.21%</td>
</tr>
<tr>
<td>2017*</td>
<td>7,222</td>
<td>893</td>
<td>8,115</td>
<td>89.00%</td>
<td>11.00%</td>
</tr>
<tr>
<td>2016*</td>
<td>7,592</td>
<td>2,616</td>
<td>10,208</td>
<td>74.37%</td>
<td>25.63%</td>
</tr>
<tr>
<td>2015*</td>
<td>7,182</td>
<td>6,390</td>
<td>13,572</td>
<td>52.92%</td>
<td>47.08%</td>
</tr>
<tr>
<td>2014*</td>
<td>7,765</td>
<td>992</td>
<td>8,757</td>
<td>88.67%</td>
<td>11.33%</td>
</tr>
</tbody>
</table>

* For years 2014-2017, this metric evaluated regulatory actions with a date of entry 90 days greater than the date of action.

Accuracy:
Note: No metrics have been defined to measure RIRS data accuracy.

Recommendations:

1. To determine use of ‘Other’ codes when existing codes may be more appropriate, add accuracy metric:
   A1. Identify regulatory actions with an ‘Other’ code and a write-in description that is identical to one of the other existing codes.

2. To determine potential excessive use of ‘Other’ codes, add accuracy metric:
   A2. Identify jurisdictions that use ‘Other’ codes in more than 20% of submitted actions.

Conclusions
After a thorough review of the analysis results and metrics themselves, the conclusion of the Market Information Systems Research and Development (D) Working Group is that for the most part the metrics are performing as desired. There are caveats associated with most of the metrics. In some cases, the results do not necessarily reflect data quality issues. However, overall, the metrics are very helpful identifying potential issues.

In addition, the majority of NAIC MIS data is of good quality overall. There are several areas where the results improved from the previous year. However, some areas in need of improvement have been identified. There appears to be an ongoing need for education and training regarding expectations and best practices for ensuring data quality. Training opportunities on the Market Information Systems, particularly MATS and MCAS are recommended for the Insurance Summit.

The Working Group will continue to review the metrics and their results and will propose recommended changes to improve the accuracy and usefulness of the metrics and the quality of the MIS data.
PRODUCER LICENSING (D) TASK FORCE

Producer Licensing (D) Task Force March 26, 2021, Minutes................................................................. 9-74
Producer Licensing Uniformity (D) Working Group March 18, 2021, Minutes (Attachment One) .......... 9-77
Uniform Education (D) Working Group March 2, 2021, Minutes (Attachment Two)............................. 9-80
The Producer Licensing (D) Task Force met March 26, 2021. The following Task Force members participated: Elizabeth Kelleher Dwyer, Co-Chair (RI); Larry D. Deiter, Co-Chair (SD); Lori K. Wing-Heier represented by Troy Murray (AK); Jim L. Riddling represented by Deborah Fike and Jimmy Gunn (AL); Ricardo Lara represented by Troy Dickinson, Charlene Ferguson and Tyler McKinney (CA); Michael Conway represented by JT Thompson (CO); Trinidad Navarro represented by Ashley Webb and Stacy Washburn (DE); David Altmair represented by Matthew Guy and Matt Tamplin (FL); Doug Ommen represented by Jackie Russo and Andria Seip (IA); Dean L. Cameron represented by Lisa Tordjman (ID); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon represented by Lorie Gasior (LA); Kathleen A. Birrane represented by Erica Bailey and Shelley Taylor-Barnes (MD); Grace Arnold (MN); Troy Downing represented by Mary Arnold (MT); Mike Causey represented by Angela Hatchell (NC); Bruce R. Ramge represented by Tracy Burns and Kevin Schlahtia (NE); Chris Nicolopoulos represented by Joan LaCourse and Christie Rice (NH); Russell Toal represented by Victoria Baca (NM); Judith L. French represented by Karen Vourvopoulos (OH); Glen Mulready represented by Courtney Khodabakhsh (OK); Andrew R. Stolfi represented by Kirsten Anderson (OR); Jessica K. Altman represented by Mike Beavers and Richard Tozer (PA); Doug Slape represented by Chris Herrick (TX); Scott A. White represented by Mike Beavers and Richard Tozer (VA); Mike Kreidler represented by Jeff Baughman (WA); Mark Aible (WI); James A. Dodrill represented by Greg Elam and Robert Grishaber (WV); and Jeff Rude represented by Bryan Stevens (WY). Also participating was: Rachel Chester (RI).

1. **Adopted its 2020 Fall National Meeting Minutes**

Mr. Baughman made a motion, seconded by Commissioner Clark, to adopt the Task Force’s Nov. 13, 2020 minutes (*see NAIC Proceedings – Fall 2020, Producer Licensing (D) Task Force*). The motion passed unanimously.

2. **Heard an Update on State Implementation of Online Examinations**

Superintendent Dwyer said 32 states have implemented remote, proctored examinations since March 2020, and 16 states are in the process of implementing them. Superintendent Dwyer said only three jurisdictions have decided not to implement remote examinations. Superintendent Dwyer said Rhode Island has not experienced issues with pass rates or other anomalies from in-person exams. Superintendent Dwyer said the Producer Licensing (D) Task Force has requested the Producer Licensing Uniformity (D) Working Group to review the examination section of the NAIC *State Licensing Handbook* since the Handbook language is based on in-person examinations only. Superintendent Dwyer said she thinks remote exams will provide better access to exams.

3. **Heard a Briefing on the NARAB Reform Act of 2015**

Karen Hornig (National Insurance Producer Registry—NIPR) said nonresident producer licensing has been discussed for more than 150 years, and the issue of uniform and reciprocal producer licensing is often used as a criticism of the state insurance regulatory system. Ms. Hornig said the purpose of the National Association of Registered Agents and Brokers (NARAB) is to create a single, national standard for nonresident insurance producer licensing.

Ms. Hornig said the federal Gramm-Leach-Bliley Act (GLBA) was passed in 1999 and contained provisions for what is referred to as NARAB I. Under the GLBA, states were provided three years to implement either licensing uniformity or licensing reciprocity and, if they could not achieve this, NARAB would be formed. In response to this, the NAIC passed the *Producer Licensing Model Act (#218)* in 2000, and the NAIC certified 35 states as having implemented licensing reciprocity in accordance with the mandates of the GLBA. Despite this effort, there was a demand for greater licensing reciprocity and uniformity, which led to the NARAB Reform Act of 2015. The NARAB Board of Directors was supposed to be in place by May 2015; however, this did not occur. Ms. Hornig said the NARAB Board is to be comprised of 13 members appointed by the president of the U.S. and confirmed by the U.S. Senate. The 13 members will be comprised of eight insurance commissioners and five members from the insurance industry.

Ms. Hornig said a licensed insurance producer may become a NARAB member and, once a member, would have the equivalent of a nonresident produce license. She said this is a similar concept to a driver’s license. Ms. Hornig said there are membership requirements, which include an individual holding a valid resident producer license and satisfying a national criminal background check.
Ms. Hornig said NARAB preempts state nonresident producer licensing laws, as well department of insurance (DOI) and secretary of state registration requirements for nonresident business entities. She said a state cannot impose continuing education (CE) or training requirements on nonresident producers who are members of NARAB; however, all state enforcement authority and licensing fees are preserved.

Ms. Hornig said a producer would have the option to either obtain nonresident licenses through NIPR and the state system or through NARAB membership. To clarify the CE requirements, Ms. Hornig said NARAB will set CE requirements for NARAB membership comparable to the CE requirements in the majority of states. In response to a question from Mr. Baughman about preemption of state training requirements, Ms. Hornig said a state could not impose flood training, suitability training or long-term care (LTC) training on a nonresident producer who is a NARAB member.

4. **Adopted the Reports of the Producer Licensing Uniformity (D) Working Group and the Uniform Education (D) Working Group**

Mr. Murray said the Producer Licensing Uniformity (D) Working Group met March 18 to discuss licensing standards for pet insurance. He said the Working Group will provide a comment period for two weeks and meet to discuss three options for the licensing of individuals selling pet insurance: 1) confirm that the current Uniform Licensing Standards (ULS) for pet insurance are the correct policy direction; 2) recommend that pet insurance become a core limited line that all states should adopt; and 3) recommend that the major lines of authority of property/casualty (P/C) be required to sell pet insurance.

Ms. Chester said the Uniform Education (D) Working Group met March 2nd and took the following action: 1) discussed the 2019 Continuing Education Reciprocity (CER) Agreement, which 44 states have signed; 2) discussed the posting of exam pass rates to the NAIC website; and 3) discussed state requirements for course instructors. Ms. Chester said the Working Group will create more uniform guidelines concerning course instructor requirements. In response to a question from Director Deiter regarding the posting of exam pass rates, Ms. Chester said the information would be posted on a state-basis, by examination vendor. Ms. Chester said there should not be any concerns with this since the information is already publicly available.

Mr. Stevens made a motion, seconded by Mr. Baughman, to adopt the reports of the Producer Licensing Uniformity (D) Working Group (Attachment One) and the Uniform Education (D) Working Group (Attachment Two). The motion passed unanimously.

5. **Received a Report from the NIPR Board of Directors**

Director Deiter said the NIPR established the COVID-19 Resource Center, a communication hub to share information about the state credentialing orders and bulletins issued by state insurance regulators. NIPR worked with 48 states on implementing more than 100 separate bulletins and orders to extend license renewal deadlines, issue temporary licenses and allow online testing.

Director Deiter said NIPR launched a major upgrade to its Attachment Warehouse application used to enable insurance producers and other licensees to upload licensing-related documents for review by state insurance regulators. This new capability for allowing additional documents to be submitted by the industry will streamline and improve the licensing application review process for the states in lieu of having the documents submitted separately. NIPR processed 38 million credentialing and report transactions in 2020, a 5.2% increase from 2019. NIPR had $47.9 million in revenue in 2020, a 5.7% increase from 2019.

Director Deiter said the NIPR Board of Directors approved a 2021–2023 NIPR Strategic Plan – Our Bridge to the Future. The plan has the following three pillars connected to NIPR’s values of teamwork, excellence, trust and innovation: 1) an engaged and empowered team; 2) customer-focused excellence; and 3) high-quality and reliable technology.

Director Deiter said NIPR has been working to bring more products and services to state and industry customers. NIPR is excited to announce that contact change requests for business entities will soon be available online through NIPR. Currently, only individual licensees may update their contact information, which includes the physical address, e-mail and phone number through NIPR. The new capability will enable business entities to utilize NIPR’s online product and eliminate the need for a separate state by state notification process for updating the entity’s contact information. Arizona, North Carolina, North Dakota and Rhode Island are expected to be implemented on April 5. NIPR plans a phased state rollout plan. NIPR is also launching a chat feature for the customer call center. Finally, NIPR has been working with California and Hawaii to implement adjuster licensing online through NIPR.
6. Received Comments from the ACLI on Race and Insurance

David Leifer (American Council of Life Insurers—ACLI) said the ACLI has made race and insurance a priority issue. Mr. Leifer said the ACLI is working on strategies to recruit minority insurance producers. He encouraged the NAIC to think about whether there are regulatory and licensing standards, such as certain background check processes, that should be reviewed. He said the ACLI supports strong background checks but questioned if certain processes, such as 1033 Waivers, could be done differently. Mr. Leifer said the implementation of remote, proctored exams is a good development and suggested states may also consider eliminating the requirement for pre-licensing education. He said pre-licensing education requirements may deter economically disadvantaged individuals from seeking a producer license and that there does not appear to be a correlation to pre-licensing education requirements and examination pass rates. Mr. Leifer said greater uniformity in resident licensing standards eliminates expenses for companies and helps companies recruit and train new candidates for producer licensing examinations.

Birny Birnbaum (Center for Economic Justice—CEJ) said he supports the ACLI’s efforts on racial justice but questioned whether the direction suggested by the ACLI will benefit communities of color. Mr. Birnbaum said the Producer Licensing (D) Task Force should review the reasons a producer licensing may be denied, suspended or revoked and whether the reason disproportionately affects communities of color due to the historically bias policing practices.

7. Discussed Procedures for Amending the NAIC Producer Licensing Applications

Director Deiter said the procedures were circulated for comment in November 2020, and comments were received from California, Washington, and the Professional Insurance Agents (PIA).

Ms. Ferguson asked what will happen to the changes the Producer Licensing (D) Task Force adopted in 2018. Director Deiter and Superintendent Dwyer said these changes were not approved by the Executive (EX) Committee and that they would work with NAIC staff to determine the appropriate next steps due to the procedures being developed. Ms. Ferguson suggested reversing steps 2 and 3 of the procedures to allow the Producer Licensing Uniformity (D) Working Group to review suggested changes and prior to the NAIC and NIPR staff providing a time and cost estimate to implement a change. Ms. Ferguson said the procedures should also address what happens if the Producer Licensing Uniformity (D) Working Group cannot agree on a suggested change. Mr. Baughman said initial conversation of changes should start with the Producer Licensing Uniformity (D) Working Group prior to the NAIC and NIPR review. Director Deiter said he understood the preference of state insurance regulators but said it also is important to understand how the suggestions might affect the business and resources of the NAIC and NIPR.

Lauren Pachman (PIA) said the timing for approving changes to the Uniform Applications is inconsistent with the timing for approving changes in the Producer Licensing (D) Task Force charges. Tim Mullen (NAIC) said he would review the procedures and charges to ensure they are consistent. Director Deiter and Superintendent Dwyer said they would work with Mr. Mullen to review the comments and circulate a revised draft of the procedures.

8. Discussed Any Other Matters

Superintendent Dwyer said the Producer Licensing (D) Task Force will be receiving a referral from the NAIC’s Special (EX) Committee on Race and Insurance and the Cannabis Insurance (C) Working Group on whether prior criminal charges are impeding individuals from obtaining an insurance producer license. Superintendent Dwyer said Rhode Island does not deny too many licenses for criminal convictions, unless it involves a felony. Because of the importance of how criminal convictions may be affecting insurance producer applicants, Superintendent Dwyer suggested the NAIC may want to review the NAIC’s Guidelines for State Insurance Regulators to the Violent Crime Control and Law Enforcement Act of 1994. Superintendent Dwyer said she would contact Commissioner Trinidad Navarro (DE), chair of the Antifraud (D) Task Force, for further coordination on this issue.

Having no further business, the Producer Licensing (D) Task Force adjourned.

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The Producer Licensing Uniformity (D) Working Group of the Producer Licensing (D) Task Force met March 18, 2021. The following Working Group members participated: Chris Murray, Chair (AK); Courtney Khodabakhsh, Vice Chair (OK); Crystal Phelps, Letty Hardee and Peggy Dunlap (AR); Charlene Ferguson, Troy Dickinson and Tyler McKinney (CA); Matt Guy (FL); Lisa Tordjman (ID); Shelley Taylor-Barnes (MD); Chris Aufenthie, Janelle Middlestead and Stephanie Butz (ND); Gina Goodro and Kevin Schlautman (NE); Hermoliva Abejar, Stephanie Kerry and Stephanie McGee (NV); Karen Vourgopoulos, Lee Washburn and Michelle Brugh Rafeld (OH); Rachel Chester (RI); Maggie Dell (SD); Randy Overstreet (UT); Mike Beavers and Richard Tozer (VA); Jeff Baughman (WA); and Melody Esquivel and Rebecca Rebholz (WI). Also participating was: Bryan Stevens (WY).

1. Discussed the Pet Insurance Licensing Standards

Mr. Murray said the Producer Licensing (D) Task Force has asked the Working Group to review the current pet insurance licensing standards and provide a recommendation on whether changes should be made. Mr. Murray said a reminder notice was sent out notifying everyone that the materials can be found on the Working Group web page. These materials include a discussion document that summarizes the work that has been completed in addition to the status of the pet insurance licensing standards. Mr. Murray said the Working Group’s goal is to discuss this topic and adopt a recommendation that can be taken back to the Task Force.

Mr. Murray said the Working Group’s task is not to discuss the pet insurance product but to focus on licensing related to pet insurance. He said discussions concerning pet insurance began in 2010 and 2011, and then they picked back up in 2017 by the Task Force. There were some concerns voiced by industry about the direction pet insurance was taking. The consensus from Task Force discussions was that those around the table did not have enough information about the product to make an informed decision. The Task Force asked the Property and Casualty Insurance (C) Committee to look at pet insurance. The Committee formed a Pet Insurance (C) Working Group, which has been working on this topic for some time now. This Working Group created a white paper on pet insurance, which was referred to the Producer Licensing (D) Task Force. The Pet Insurance (C) Working Group is also working towards the creation of a model law for pet insurance, which will deal with consumer protection and aspects related to policy.

Mr. Murray said pet insurance is currently addressed in the NAIC Uniform Licensing Standards (ULS), which list pet Insurance as a non-core limited line. The ULS non-core limited line states that a state is not required to implement any non-core line of authority for which a state does not already require a license or that is not already incorporated with a major line of authority. Mr. Murray said if a state offers a non-core limited line such as pet insurance or legal expenses, it shall do so with specific licensing requirements listed in the ULS. Basically, a state does not have to implement a non-core limited line for which a state does not already issue that license. Mr. Murray said at this time, four states have made pet insurance a non-core limited line license. The remaining states have this license sold under a property/casualty (P/C) license. This is consistent with current ULS non-core limited lines. The goal of the Producer Licensing Uniformity (D) Working Group is to determine whether this is the correct path or if other requirements should be looked at.

Mr. Murray said the Working Group will need to look at three different potential recommendations: 1) confirm that current ULS for pet insurance is correct policy direction; 2) recommend that pet insurance become a core limited line all states shall adopt; or 3) recommend that the major lines of authority of P/C be required to sell pet insurance.

Mr. Murray said the purpose of today’s meeting is to initiate an open discussion with state insurance regulators and industry to find common ground in order to move forward with confirming the best recommendation. He said the pet insurance product is currently a P/C product at this time, and it is not within the Working Group’s scope of authority to change this but to review the standards.

Ms. Tordjman said Idaho licenses pet insurance as a non-core limited line. She said pet insurance is not a limited line and is not considered incidental insurance. Ms. Tordjman said more work needs to be done and to determine if it belongs under P/C lines. She said the products generated from pet insurance are more complicated and mimic some provisions of health insurance.
Mr. Baughman said Washington has been very vocal concerning pet insurance. He said Washington thinks it should be a P/C license rather than limited line due to the complexity of the product, much like health insurance. Mr. Baughman said a pet is considered property and not a person. Therefore, it belongs under the P/C line of authority. Mr. Guy said Florida echoes Washington’s comments and that Florida has concerns for nefarious characters that may take advantage of these complex products. Mr. Guy said he does have concerns regarding the marketing of this product.

Ms. Chester said Rhode Island has pet insurance as a limited line due to the history with how the product is sold. She said it would be helpful to understand how this product has changed from the way it was traditionally marketed.

Mr. Murray said the pet insurance white paper outlines some of the concerns with this product and encourages everyone to review and make themselves aware of the concerns and changes in this product that have made it a relevant discussion at this time. He said to his knowledge, there are no specific questions for pet insurance on a P/C examination.

Ms. Ferguson said California added pet insurance objectives to its P/C license examination based off the information found in the pet insurance white paper concerning disclosures and requirements.

Mr. Baughman said there are a lot of policies that are not included into an exam for other licenses. He said this is something to keep in mind when reviewing the pet insurance licensing standards. Mr. Baughman said Washington language says that if someone wants a pet insurance license, it would be provided under a P/C license and, therefore, would not have oversight over pet insurance specifically.

Ms. Ferguson said the authority of the individual is granted in the resident state if an investigation goes on or if a consumer complaint is received. She said the nonresident stated would then need to contact the home state, which caused more of a reactive instead of proactive stance.

Mr. Murray said that the issues that have been raised have been addressed with the way it is written currently. He said he asks what there is with the pet insurance license that would suggest the current standards need to be changed.

Ms. Chester said it is an incidental product. A pamphlet in a veterinarian office is different from a call center for other products. Ms. Chester said they are not seeing this in Rhode Island, but it may be taking place in other states.

Mr. Stevens asked if the Working Group starts reviewing pet insurance, would that open the door for other incidental products to be pieced out. Mr. Murray said while this is a relevant concern, the Working Group has been given the task to review this standard specifically.

Mr. Baughman said out of 55 jurisdictions, there are 51 that have this as P/C. This would cause these 51 jurisdictions to change legislation in order to add this as a limited line. Mr. Murray said this is current and significant for the Working Group to consider when reviewing the different options for recommendations.

LeeAnn Goheen National Association of Insurance and Financial Advisors—NAFIA) said they support a limited line approach but think it should be a robust testing and exam standards.

Paul Williams (Unum) said Unum’s perspective, as a company that operates in life and health, is that there is a lot of interest in pet insurance. He said Unum is not able to offer this product because its agents are not licensed in P/C. Mr. Williams said this prohibits growth potential. He said Unum supports pet insurance being made into a core limited line, which would allow it to offer this product.

Mr. Murray said one of the ways that pet insurance is growing is through employer benefit programs. He said it is important for the Working Group to recognize this when reviewing our recommendation.

Jack Chaskey Society for the Prevention of Cruelty to Animals—SPCA) said one of the advantages of limited lines is the point of sale and the ability to make the financial responsibility with the insurance product. Mr. Chaskey said this is when the consumer needs protection. He said the appropriate standards will not only protect consumers, but also, they will provide appropriate avenues to provide this product safely.

Jeanie Keller said that licensure is not a barrier to sales of insurance products. Licensure is a consumer protection and fail-safe to make sure that trained people are offering the product.
Ms. Ferguson said one item of interest for the P/C producers who do sell pet insurance is if those in the insurance industry who are selling pet insurance become an education provider. She said to have them offer courses specific to pet insurance, which will provide an avenue to learn what they need to know. Ms. Ferguson said this would add to the 24 hours of continuing education (CE) that the person would need to complete anyway. She said this would be part of the education course, which would assist this individual with gaining knowledge on this product.

Mr. Murray said the next step will be to send out an email soliciting comments on the pet insurance standards. He said the comments will be discussed and a survey request will be distributed for the Working Group members to provide their preference. Mr. Murray said the Working Group will then meet to adopt the best recommendation. He said once the Working Group adopts the recommendation, it would be presented to the Task Force for consideration.

Having no further business, the Uniform Education (D) Working Group adjourned.
The Uniform Education (D) Working Group of the Producer Licensing (D) Task Force met March 2, 2021. The following Working Group members participated: Rachel Chester, Chair (RI); Mike Beavers, Vice Chair (VA); Chris Murray (AK); Charlene Ferguson (CA); Vanessa Miller (MS); Karen Vourvopoulos (OH); and Jeff Baughman (WA).

1. **Discussed the CER Agreement Signature Status**

Ms. Chester provided a brief overview of the 2019 Continuing Education Reciprocity (CER) Agreement. Ms. Chester said the Working Group has received 43 signatures from state insurance commissioners on the 2019 CER Agreement. She said she will continue working with NAIC staff to reach out to states and obtain the remaining signatures.

2. **Discussed Exam Pass Rates**

Ms. Chester said the tracking of exam pass rates has been a topic of discussion off and on for the past few years. She said originally NAIC staff went directly to the states to request the pass rate data. She said the decision was made a few years ago that the testing vendors would send the states’ first-time pass rate data to NAIC staff, which would compile and post on the Working Group website. Ms. Chester said a new format was created and advised the Working Group members that she would be speaking to the testing vendor directly to clear up any confusion and simplify the process.

3. **Discussed the Creation of Course Instructor Requirements.**

Ms. Chester said she has been working with NAIC staff to review the RegEd instructor qualifications document created in 2020, which lists each state and its specific qualifications. Ms. Chester said the plan is to review these qualifications to determine common denominators that can be used for the creation of NAIC uniform course instructor requirement guidelines. Ms. Chester said the Working Group will meet in May to further discuss and begin the first steps to finalize this project.

Having no further business, the Uniform Education (D) Working Group adjourned.
FINANCIAL CONDITION (E) COMMITTEE

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The Financial Condition (E) Committee met April 13, 2021. The following Committee members participated: Scott A. White, Chair (VA); Michael Conway, Vice Chair, represented by Rolf Kaumann (CO); Dana Popsh Severinghaus (IL); Stephen W. Robertson represented by Roy Eft (IN); Eric A. Cioppa (ME); Chlora Lindley-Myers represented by Shannon Schmoeger (MO); Mike Chaney represented by David Browning (MS); Marlene Caride (NJ); Russell Toal (NM); Linda A. Lacewell represented by My Chi To (NY); Judith L. French (OH); Raymond G. Farmer represented by Michael Shull (SC); Doug Slape, Jamie Walker and James Kennedy (TX); Mark Afable (WI); and Jeff Rude (WY). Also participating were: Russ Galbraith (AR); James J. Donelon (LA); and Glen Mulready (OK).

1. **Adopted its March 8 and 2020 Fall National Meeting Minutes**

Commissioner White said the Committee met March 8 and took the following actions: 1) adopted a request for extension from the Mortgage Guaranty Insurance (E) Working Group; 2) adopted a new charge for the Qualified Jurisdiction (E) Working Group and a change to reposition the Working Group to report directly to the Committee; and 3) adopted proposed recommendations to the Financial Regulation Standards and Accreditation (F) Committee with respect to the group capital calculation (GCC) and the liquidity stress test (LST).

Commissioner Rude made a motion, seconded by Commissioner Caride, to adopt the Committee’s March 8 (Attachment One), and Dec. 8, 2020, **(see NAIC Proceedings – Fall 2020, Financial Condition (E) Committee)** minutes. The motion passed unanimously.

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

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

Superintendent Toal made a motion, seconded by Commissioner Caride, to adopt the following task force and working group reports: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Examination Oversight (E) Task Force; Financial Stability (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention Group (E) Task Force; Valuation of Securities (E) Task Force; Group Capital Calculation (E) Working Group (Attachment Two); Group Solvency Issues (E) Working Group (Attachment Three); Mortgage Guaranty Insurance (E) Working Group (Attachment Four); and National Treatment and Coordination (E) Working Group (Attachment Five).

The Financial Analysis (E) Working Group met Jan. 27, Feb. 24, and March 17 in regulator-to-regulator sessions, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss letter responses and financial results. Additionally, the Valuation Analysis (E) Working Group met March 25 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss valuation items related to specific companies. Finally, the Risk-Focused Surveillance (E) Working Group met March 24 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings.

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

Mr. Kennedy noted that the Receivership and Insolvency (E) Task Force adopted the Guideline for Definition of Reciprocal State in Receivership Laws as a possible option to effectuate the recognition of receiverships that affect multiple states. He highlighted that this was one of the recommendations that was derived from the Macroprudential Initiative (MPI) on recovery and resolution from the referral from the Financial Stability (E) Task Force. He described how receivership laws typically...
provide for a stay of actions on the attachment of assets of an insurance company when it is placed into liquidation in a reciprocal state. In many states, the definition of reciprocal state is based upon receivership language originally drafted in the late 1970s, and it is more restrictive than the Part A Accreditation Standards. As a result, in some cases, a court may not stay a litigation when an insurance company is placed into liquidation in another state. The Guideline’s definition of reciprocal state is consistent with the definition in accreditation standards; and because it is a guideline, it is optional and would not have to be adopted in all states but rather is for those states looking to update their laws in this area. Mr. Kennedy stated that in November 2020, it was exposed for public comment, and there were no comments submitted.

Commissioner Caride made a motion, seconded by Mr. Kaumann, to adopt the Guideline for Definition of Reciprocal State in Receivership Laws (Attachment Six). The motion passed unanimously.

4. Adopted a Charge for the New Receiver’s Handbook (E) Subgroup

Mr. Kennedy stated that the Receivership and Insolvency (E) Task Force adopted amended 2021 charges that include the formation of the new Receiver’s Handbook (E) Subgroup. He stated that it has been over 10 years since the Receiver’s Handbook for Insurance Company Insolvencies (Handbook) was formally reviewed for updates, and the state insurance regulators have identified several areas where it is outdated. He noted how the new Subgroup would be charged with reviewing and drafting revisions to the Handbook. The timeline would extend through the 2022 Fall National Meeting, as this project could take some time.

Superintendent Toal made a motion, seconded by Commissioner Caride, to adopt a charge for the new Receiver’s Handbook (E) Subgroup (Attachment Seven). The motion passed unanimously.

5. Adopted Changes to SSAP No. 71

Commissioner White stated that the last item on the agenda is an issue that has received a considerable amount of discussion within the Statutory Accounting Principles (E) Working Group over the last couple years. He stated that unlike the premium refund issue from 2020, where the Committee overturned the adoption of a position and suggested that the issue be redrafted, he does not believe that should occur for this particular issue. He stated that the reason for this was that it was his understanding that the vast majority of the life insurance industry is very much opposed to the practice that has apparently been used by what we think is a handful of companies. The reason being is they believe it gives those handful of companies an unfair competitive advantage over the rest of the industry that has been abiding by Statement of Statutory Accounting Principles (SSAP) No. 71—Policy Acquisition Costs and Commissions ever since its inception, as well as even dating back before at least the 1990s according to Commissioner White’s staff. He suggested that if the Committee does not adopt this item, his understanding is that it would force the Working Group to change the entire SSAP No. 71 to allow all commissions and related acquisition costs to be deferred and amortized over time. The reason this would be required is that is essentially what the handful of companies are doing today, while the rest of the industry expenses these costs at the inception of the contract in accordance with statutory accounting principles (SAP). Commissioner White summarized that this would require the Working Group to go back and basically adopt U.S. Generally Accepted Accounting Principles (GAAP) for this particular issue, even though this is one of the biggest differences between SAP and U.S. GAAP. He noted that even if the Committee adopts the issue, it still needs to be adopted by the Executive (EX) Committee and Plenary. He also noted that he already recommended that this issue not be taken up by the Executive (EX) Committee and Plenary at the Spring National Meeting, but rather the Executive (EX) Committee and Plenary consider taking it up either at the Summer National Meeting or during an interim call of the Executive (EX) Committee and Plenary.

Ms. Walker noted that included in the materials is a document that provides an overview of the levelized commission agenda item 2019-24 from the Working Group, which modifies SSAP No. 71 through a clarification. She discussed how the Working Group began discussion on the issue in August 2019, and on March 15, 2021, the Working Group adopted nonsubstantive revisions illustrated at the end of the attachment, with an effective date of Dec. 31, 2021. The Working Group vote was 13 states in favor and one state opposed. On March 23, 2021, the Accounting Practices and Procedures (E) Task Force adopted the Working Group’s revisions without modification. The vote was 41 members in favor and two opposed (LA and OK).

Ms. Walker discussed that although U.S. GAAP and SAP calculate acquisition costs in a similar manner, one major financial reporting difference between the two is that U.S. GAAP capitalizes acquisition costs and expenses them over time to match revenues and expenses while SAP expenses policy acquisitions costs as incurred. This accounting treatment is in line with the SAP Statement of Concepts, particularly the recognition concept. This concept specifically identifies that accounting treatments that defer expense recognition are not generally acceptable under SAP.
Ms. Walker noted that this agenda item was initiated because some reporting entities are using third parties to pay their sales commission costs without recognizing the full liability to repay the third parties, as required under SSAP No. 71. These entities have taken the position that their agreements are not funding agreements, as they pass on lapse risk to the third party. Ms. Walker discussed how the Working Group has noted that the revisions clarify the long-standing principles in SSAP No. 71, which have existed since even prior to codification. The nonsubstantive revisions emphasize the original principles that require full liability recognition for the commission paid on an insurer’s behalf and any interest and fees incurred to date. Ms. Walker described how the Working Group noted that it is not permissible to pass insurance lapse risk to a non-insurance entity. Furthermore, as the commission is owed with the issuance of an insurance contract, the proper recognition shall continue to require recognition at the time the insurance contract is issued. Ms. Walker indicated that the Working Group confirmed that it is not permissible to utilize a third-party payer of sales commission as a means to defer recognition of commission expenses.

Ms. Walker described how if the agenda item is adopted, a small number of companies will have a material financial impact. She emphasized that because of the unfair competitive advantages that are perceived, and as the guidance is in line with the original intent of SSAP No. 71, the Working Group did not adopt grandfathering or transition provisions. She discussed how the Working Group has recommended that affected companies speak to their domiciliary states regarding potential permitted practices, as needed, for phasing in the financial impact. This approach was favored because the impact to the affected companies may vary, and it provides disclosure in Note 1 to ensure the comparability of all insurers with SAP. Ms. Walker noted that it is her understanding that most companies are not employing this practice and will not be affected by the agenda item’s adoption.

Superintendent Toal suggested that the Committee should consider modifying the effective date from the current proposed year-end 2021 for another year to year-end 2022. Ms. Walker stated that the Working Group had already delayed the effective date from its usual practice of effective upon adoption for nonsubstantive items such as this, but the Working Group wanted to allow time for domestic states to work with any of their companies affected. She also described how a further delay was considered, but since the vast majority of the industry is complying, such a suggestion was rejected by the Working Group. Superintendent Toal questioned whether having less than six months allows enough time for companies to make the changes necessary. Commissioner Donelon repeated a comment that he indicated he has made in the past, which was that even though this was not a substantive change, the real-world impact to some companies was to the tune of hundreds of millions of dollars; therefore, grandfathering of the old contracts, perhaps on a phased-in approach, should be allowed. He described that he had been directed to some communication from the U.S. Securities and Exchange Commission (SEC) where this practice was uncovered as far back as 30 years ago. He described how such companies therefore may have been using this practice in good faith, or at least one they believed was appropriate, and they are being asked to record hundreds of millions of changes in surplus from this practice. He stated that for this reason, he and other commissioners have interceded in this process. Commissioner White described how he believes that Commissioner Donelon summarized that significant debate that has already appropriately occurred on this issue. Commissioner White described how everything he has been told is that this may have been taking place within a handful of companies, but that does not mean the state insurance regulators of those companies were aware of its existence in those companies. He described how this is not readable or identified in the financial statements since it is an unrecorded liability. He described how expensing these costs as incurred has been a bedrock principle within statutory accounting for years, even before SSAP No. 71 was adopted in 2001. He noted that he understands the argument for phasing in the impact, given that it could be material for some companies; however, the other side of that is the argument about the level playing field. He emphasizes what Ms. Walker said earlier about affected companies working with their domestic regulator about a permitted practice, which is disclosed in Note 1 of the financial statements. Commissioner Donelon stated that he believes from his experience as a commissioner for so many years that the term “permitted practice” certainly comes with a negative connotation. He stated that for the companies he has heard from, the affected companies are unwilling to pursue a permitted practice. However, he stated his appreciation for the time that the Committee and its subsidiary task forces and working groups have given to this issue.

Mr. Galbraith asked if it is possible to determine definitively if there were just a handful of companies and also whether the practice will definitively cease with all companies going forward on the same level playing field if the proposed changes are adopted. Commissioner White stated that he has heard no evidence to the contrary that it was anything more than a handful of companies since he believes state insurance regulators would have heard from those companies that are affected, and he noted that he is aware of companies in only three states where this is an issue. He described how this is a difficult practice to identify since it is not recorded in the financial statements. He also stated that with the significant discussion, the industry appears to be very aware of the issue, and the vast majority of the industry is supportive of the clarification. He emphasized again therefore that this issue boils down to having a level playing field.

Commissioner Mulready stated his support for the comments made by Commissioner Donelon, noting that his concerns have never been about the issue but rather the implementation. He stated his understanding that grandfathering may be difficult, but
a delayed effective date, as suggested by Superintendent Toal, should be considered. Commissioner White responded that he believes that point was debated at the Working Group and the Accounting Practices and Procedures (E) Task Force. Commissioner Mulready noted that as a result of these discussions, Oklahoma had sent communication to all of its domestics to determine if other insurers are affected, and he suggested that he is sure other states are likely doing the same thing. Commissioner White stated his support for that practice, noting that it allows the domestic regulator to determine what is best for any affected companies. Wayne Goodwin, former North Carolina Insurance Commissioner, stated that he had previously submitted comments on this issue, noting slippery slope concerns with what could happen if it is implemented as quickly as is suggested since those concerns affect consumers. He stated his support for comments from Commissioner Donelon, Commissioner Mulready and Mr. Galbraith, and he noted concern about the potential impact on smaller carriers.

Superintendent Toal stated that he wants to be clear in the idea of moving to a level playing field, and he is not objecting to the policy, rather his objection was with the limited time to implement, particularly given that state insurance regulators do not know the number of companies affected. Commissioner White responded that his deputy refers to the issue that arises from this practice as illusory surplus, and if in fact there are millions in unrecorded liabilities, that indicates information should be available to solvency regulators and indicates a level of concern. Ms. Walker stated that she believes this is a consumer protection issue, and her highest responsibility is ensuring that carriers can pay policyholder claims as they come due. She stated that when she hears some of the concerns that are being stated, as the domiciliary regulator, she needs the companies to come speak to her so that the two can work out a practice that takes care of consumers while considering the concerns of the company. She stated that the Accounting Practices and Procedures Task Force is trying to adopt some disclosures to gather information on companies, but that depends upon accurate completion by the company, something that may not occur given this particular accounting practice of expensing commissions as they are incurred, which is a fundamental bedrock of statutory accounting that differs from other standards. She noted that there was discussion of trying to obtain more data on the companies using this practice, but the companies did not come forward to their state insurance regulator even though that was requested. So, while a complete scope is not known, the Working Group and the Task Force did not receive information from state insurance regulators that are on the Task Force or follow it. Ms. Walker also noted that the current proposed effective date of year-end 2021 is already a delay. Mr. Slape suggested that if this is going to have hundreds of millions of impacts on a handful of companies, that is illusory surplus, and that raises questions about the solvency of such insurers using this practice. Therefore, it could have an impact on this small number of companies. Mr. Slape stated that the reference to SEC action may not be accurate, as he believes the facts indicate that the company was in worse financial condition after entering into these transactions. In essence, these companies are borrowing money, paying interest on that borrowed money, then competing against other companies that are following the current accounting requirements. Mr. Slape noted that this is not a new issue; this is the first thing that a state insurance regulator learns about regarding the differences between SAP and U.S. GAAP.

Lynn Kelley (Delaware Life Insurance Company), on behalf of interested parties, stated that this is an issue that has been discussed for some time, and she appreciates the ongoing discussions of the Committee and NAIC staff that have worked with Delaware Life. She strongly advocated for additional time to work through this implementation because Delaware Life still believes there are unanswered questions with regard to the calculations. She stated that Delaware Life has advocated all along for an extended effective date. She stated that Delaware Life maintains that this is a substantive change and believes that it has applied SSAP No. 71 in good faith, with all prior financial statements subject to examination and audit. Terrance Corbett (Guggenheim Life and Annuity Company) stated that the accounting for levelized commissions has been presented as a solvency issue, whereby companies have unrecorded liabilities for future commission payments. If this is the case, the liability is deemed necessary for policyholder protection, so how would the Committee be comfortable with any persistency commissions being recorded over time when all insurers have policy experience to be used as a basis for estimating the liability for these future expected payment payments. Therefore, the obligating event, which is defined by one of three essential characteristics in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets, has not occurred until the policy anniversary date. Mr. Corbett noted that paragraph 2 of SSAP No. 71, which contains no proposed modifications to the definition of a liability, determine that the expense has been incurred. The proposed changes to levelized commissions with a link to persistency are contradictory to paragraph 2. Commissions that are paid and earned according to persistency, which is a long-standing insurance element, should be treated in a consistent manner to ensure comparability among reporting entities. Guggenheim believes the proposed changes to SSAP No. 71 sets a dangerous precedence for the need to accrue for other liabilities for other predictable future expenses. Ms. Walker noted that the expense is incurred for the first year when the policy is written. So, even if the funding agreement allows the company to pay the sales agent in the future, that does not allow the company to defer expenses the first year of the policy. She stated that by deferring, and not recording the liability, and making the statement that it is not due until after the period is contrary and has a different assumption. The assumption that one does not have to book the liability until the policy is still in effect ignores the fact that the policy is currently in effect. As long as the policy is in effect, that amount will be owed. Therefore, you are not to adjust the liability down until the policy lapses or is cancelled. Using a funding agreement simply changes the timing of when the payment is due and does not affect if there should be an expense. Mr. Slape said these are not persistency commissions because in those situations the agent is paid a commission

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in future years for when that policy stays in force. These are referred to as renewal commissions, and they are reported on the future anniversary date, but the first-year commission must be expensed immediately up front regardless of the existence of a funding agreement since that is a loan. Mr. Slape stated that he takes issue with the statement that these funding agreements provide for a persistency commission.

Roger Sevigny (Sevigny Consulting), as a former state insurance regulator, asked for common sense to prevail. He stated that what he keeps hearing is a lack of information, and he asked that the work be slowed down. Commissioner Donelon stated that with respect to the companies referred to, they are owned by wealthy owners and some of the largest insurers in the world. Commissioner White stated that the debate has been vigorous, and he reminded everyone that even if the Committee votes to adopt the proposal, it will still need to be considered by the Executive (EX) Committee and Plenary. He stated that he has recommended that the Executive (EX) Committee and Plenary not consider this at this meeting, but rather at the Summer National Meeting or during an interim meeting before that date.

Ms. Walker made a motion, seconded by Superintendent Cioppa, to adopt the nonsubstantive changes to SSAP No. 71 (Attachment Eight). The motion passed with Mississippi, New Mexico, and South Carolina dissenting.

Having no further business, the Financial Condition (E) Committee adjourned.
The Financial Condition (E) Committee met March 8, 2021. The following Committee members participated: Scott A. White, Chair (VA); Michael Conway (CO), Vice Chair, represented by Rolf Kaumann (CO); Dana Popsh Severinghaus represented by Kevin Fry (IL); Stephen W. Robertson represented by Roy Eft (IN); Eric A. Cioppa (ME); Mike Chaney represented by David Browning (MS); Chlora Lindley-Myers and John Rehagen (MO); Marlene Caride (NJ); Russell Toal (NM); Linda A. Lacewell represented by My Chi To and Bob Kasinow (NY); Judith L. French (OH); Raymond G. Farmer (SC); Doug Slape represented by Jamie Walker (TX); Mark Afable (WV); and Jeff Rude (WY).

1. Adopted a Model Law Development Request Extension

Commissioner White described how the NAIC model law process requires the sponsoring committee to request from the Executive (EX) Committee the authority to work on modifying a particular NAIC model. He noted that in this context, permission was granted some time ago for the Mortgage Guaranty Insurance (E) Working Group to do so, but since such work had begun, most of the time had been spent developing a capital model that would essentially prevent mortgage insurers from lowering their lending standards similar to what occurred during the 2008 financial crisis. He described how he knew this was a time-consuming process in part because of the limited amount of state resources to work on this project. He said that approximately two years ago, the current chair, North Carolina, began an effort to create a more simplified version of a previously proposed capital model, with the model focused on loan-to-value ratios, FICO scores, housing market information and other signs of previous poor standards. Commissioner White said that due to COVID-19 and other state priorities, no work was conducted on this project in 2020, and the request is for an extension given these circumstances.

Director Farmer made a motion, seconded by Commissioner Caride, to adopt the request for extension from the Mortgage Guaranty Insurance (E) Working Group (Attachment One-A). The motion passed unanimously.

2. Adopted a New Proposed Charge and Request for Restructuring

Dan Daveline (NAIC) stated that the Group Capital Calculation (E) Working Group requests that a new charge be given to the Qualified Jurisdiction (E) Working Group related to the “Recognize and Accept” process already incorporated into the December 2020 version of the NAIC Insurance Holding Company System Model Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). He described how the suggestion includes renaming the Qualified Jurisdiction (E) Working Group to the Mutual Recognition of Jurisdictions (E) Working Group since it is proposed that the Working Group continue to fulfill its existing charges related to maintaining the qualified and reciprocal jurisdiction lists, but also take on developing and maintaining this new list related to group capital that also focuses on considering the recognition of other jurisdictions.

Superintendent Cioppa made a motion, seconded by Commissioner Caride, to adopt the proposed new charge and rename the group as recommended (Attachment One-B). The motion passed unanimously.

3. Adopted Suggested Accreditation Standards

Commissioner Caride discussed how during the Financial Stability (E) Task Force’s meeting on Feb. 22, it adopted the recommendation proposed including the liquidity stress test (LST) changes to Model #440 as an accreditation requirement, as well as the corresponding requirements for the specific standard. She indicated that two items worthy of note were discussed. First, regarding the timing considerations, the Task Force supported the timely adoption of the LST changes to Model #440, especially for those lead states of the 23 in-scope insurance groups for the 2020 LST. However, the Task Force agreed that the timing of adoption for accreditation purposes was something that should be determined by the Financial Regulation Standards and Accreditation (F) Committee. Commissioner Caride noted the Texas member representative indicated some concerns with the timing considerations but agreed that those were not decisions for the Task Force and could be discussed with that Committee.
Second, Commissioner Caride said the Task Force amended its draft recommendation letter during the meeting in an attempt to address some of the comments from the American Council of Life Insurers (ACLI) regarding the “substantially similar” standard elements. The ACLI comment letter asked for inclusion of each of the confidentiality clauses in the LST revisions to Model #440. The Task Force’s concern with the ACLI comments was the likelihood of attaining such specific language for each confidentiality clause when the LST revisions to Model #440 go before the many different legislatures across the country. She stated that because of this, the Task Force proposed an amendment to balance the ACLI’s request with the Task Force’s concern. Commissioner Caride explained that the Task Force added a new paragraph to the recommendation, making it consistent with the accreditation substantially similar elements for confidentiality provisions in the Risk Management and Own Risk and Solvency Assessment Model Act (#505). While industry’s initial read of the amended language was favorable, they did not have an opportunity to consider it at length, nor had the ACLI been able to discuss any potential concerns with its member companies. However, no one was opposed to the Task Force finalizing the amended recommendation and referring it to this Committee.

Commissioner White repeated a comment from Commissioner Caride that he found to be important, which was that he believed it was part of the Committee’s role to advance these recommendations since ultimately the matters noted are decisions to be made by the Financial Regulation Standards and Accreditation (F) Committee.

Commissioner Caride made a motion, seconded by Commissioner Afable, to adopt the recommendations to the Financial Regulation Standards and Accreditation (F) Committee related to the LST. The motion passed unanimously.

Mr. Rehagen stated he wanted to highlight a few items related to the accreditation recommendations related to the group capital calculation (GCC). First, he indicated they received suggestions from two parties related to the cover memorandum. The first was from South Dakota, who suggested adding language to the document to describe the reason the Working Group was recommending that the GCC be an accreditation standard for all states. Mr. Rehagen directed participants to the second paragraph of the memorandum, where they added language to the third line that speaks to how the GCC will allow states to better understand an insurance group’s financial risk profile for the purpose of enhancing policyholder protections. He described how it does this largely through its quantification of risk and described how they reworded the second to last sentence about how that makes these things more identifiable and quantifiable. He also described how they added the last sentence to denote that this entire paragraph was the reason the Working Group believed the GCC should be an accreditation standard for all states. Mr. Rehagen noted that the revised language was not adopted by the Working Group, but the Working Group did instruct NAIC staff to add language to make this clearer, which Mr. Rehagen noted he believed the revised language did so.

Mr. Rehagen described how the second item was from America’s Health Insurance Plans (AHIP), which suggested the memorandum should clearly identify why the Working Group has recommended that a more expeditious process be used for some states, for which the Working Group recommended the GCC be required to be in place by Nov. 7, 2022, for purposes of the compliance with the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) or the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement). He discussed that this recommendation only pertains to those states that are the group-wide supervisor of a U.S. group that operates in either the United Kingdom (UK) or the European Union (EU). Mr. Rehagen noted that this language was not something the Working Group asked to be made, but as Working Group chair, he authorized inclusion of the last sentence since it ties the discussion on the EU Covered Agreement and the UK Covered Agreement to the expeditious process suggested later in the document.

Mr. Rehagen asked to highlight two additional items. First, in the actual proposed standards, a number of areas include striking the word “substantially” before “similar.” This is because the general practice in the standards is that the entire model be worded with the word “substantial,” and subject to that standard, but that the rest of the document just refer to “similar.” He noted that during the Working Group meeting, he had asked that NAIC staff make those corrections. He also stated he wanted to highlight the language stricken on standard L6. In that paragraph, the Working Group deleted the words “or for ensuring the competitiveness of the insurance marketplace.” He stated he was highlighting this because the language struck is in Model #440, but the Working Group voted to have it removed. Mr. Rehagen ended by stating he wanted to make the same point as Commissioner Caride, which was he felt their job was to develop these recommendations for the GCC, but that ultimately the decision will be made by the Financial Regulation Standards and Accreditation (F) Committee. Commissioner White agreed with Mr. Rehagen’s statement.

Mr. Rehagen made a motion, seconded by Commissioner Caride, to adopt the recommendations to the Financial Regulation Standards and Accreditation (F) Committee related to the GCC. The motion passed unanimously.

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Commissioner Caride made a motion, seconded by Superintendent Cioppa, to adopt a cover memorandum from the Committee to the Financial Regulation Standards and Accreditation (F) Committee to accompany the recommendations adopted from the Task Force and the Working Group. The motion passed unanimously.

Having no further business, the Financial Condition (E) Committee adjourned.
To: Commissioner Scott White (VA), Chair, Financial Condition (E) Committee  
From: Kevin Conley (NC), Chair, Mortgage Guaranty Insurance (E) Working Group  
Date: January 5, 2021  
Re: Updated Request for Extension

The Mortgage Guaranty Insurance (E) Working Group is in the process of fulfilling its charge to update the Mortgage Guaranty Insurance Model Act (Model #630). The Working Group anticipated completion of its Charge by the 2021 Spring National Meeting. As chair, I would like to update that request to the Financial Condition (E) Committee in accordance with NAIC procedures.

As background, the NAIC engaged Milliman to assist the Working Group in finalizing a Mortgage Guaranty Insurance Capital Model that will become the new capital standard for mortgage insurers. Subsequent to discussion at the 2019 Fall National Meeting, the Working Group exposed the Draft Mortgage Guaranty Insurance Capital Model, Mortgage Guaranty Insurance Model Act (#630), Mortgage Guaranty Insurance Standards Manual, and a proposed Mortgage Guaranty Insurance Exhibit. As result of issues in work efforts due to COVID, the Working Group did not meet during 2020. The Working Group will reconvene and discuss comments received on the exposure and send a referral to the Blanks (E) Working Group regarding the proposed exhibit during the next couple of months.

At this time, we believe we can complete this work by the 2022 Spring National Meeting. The request for additional time is to allow the necessary time to address comments regarding the above referenced documents and ensure that a comprehensive regulatory framework is in place to effectively regulate these complex insurance entities. We are aware that we have been unable to complete our work within the one-year time period expected under the NAIC model law process and request an extension until the 2022 Spring National Meeting in order to finalize a product that can be adopted by the domestic states of the mortgage insurers, as well as any other state also wishing to adopt the same.
MEMORANDUM

To: Financial Condition (E) Committee

From: Group Capital Calculation (E) Working Group

Date: February 25, 2021

Re: Proposed New Charge for the Recognize and Accept Process

On Dec. 9, 2020, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC Insurance Holding Company System Model Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). These revisions will enable the Group Capital Calculation (GCC) once adopted by the states. The revisions specifically include provisions that allow the Commissioner to exempt groups that have a group-wide supervisor that “recognize and accept” the GCC for U.S. groups in their jurisdiction; thereby embracing the concepts of mutual recognition and one group/one group wide supervisor. Model #450 provides a general framework for how the “recognize and accept” process will work and specifically contemplates the development of “a list” of such jurisdictions. This concept of a list in the context of mutual recognition is not a new one and is already used by the Qualified Jurisdiction (E) Working Group of the Reinsurance (E) Task Force. To that end, the Working Group recommends the Financial Condition (E) Committee reposition the group to report directly to the Committee, modify the charges of the Qualified Jurisdiction (E) Working Group as shown below, and revise the title of the group to be more encompassing, as also shown in the following:

2021 Charges

The Qualified Mutual Recognition of Jurisdictions (E) Working Group will:

1. Develop a process for evaluating jurisdictions that meets the NAIC requirements for recognizing and accepting the NAIC Group Capital Calculation (GCC).
2. Maintain the NAIC List of Qualified Jurisdictions and the NAIC List of Reciprocal Jurisdictions in accordance with the Process for Evaluating Qualified and Reciprocal Jurisdictions.
3. Perform a yearly due diligence review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions.
4. Consider evaluations of any additional jurisdictions for inclusion on the NAIC List of Qualified Jurisdictions.

If you have any questions, please contact NAIC staff support Dan Daveline (ddaveline@naic.org).
Group Capital Calculation (E) Working Group
Virtual Meeting
March 10, 2021

The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met March 10, 2021. The following Working Group members participated: John Rehagen, Chair (MO); Kathy Belfi, Vice Chair (CT); Susan Bernard (CA); Ray Spudeck (FL); Carrie Mears (IA); Susan Berry (IL); Roy Eft (IN); Christopher Joyce (MA); Judy Weaver (MI); Barbara Carey (MN); Jackie Obusek (NC); Justin Schrader (NE); Dave Wolf (NJ); Bob Kasinow (NY); Dale Bruggeman and Tim Biler (OH); Greg Lathrop (OR); Melissa Greiner and Kimberly Rankin (PA); Trey Hancock (TN); Mike Boerner (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).


During its Feb. 25, 2021, meeting, the Working Group took the following action: 1) adopted recommended accreditation standards for referral to the Financial Condition (E) Committee related to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450); and 2) adopted a recommendation to the Financial Condition (E) Committee to modify the charges of the Qualified Jurisdiction (E) Working Group and revise the title of the group to be more encompassing. During its Jan. 28, 2021, meeting, the Working Group took the following action: 1) heard a presentation on the data analysis for the adopted group capital calculation (GCC) template using 2019 field test data; and 2) discussed further GCC data collection. The Working Group conducted an e-vote that concluded Jan. 19 to expose the proposed accreditation standards for the GCC.

Mr. Spudeck stated that he had attended the Feb. 25, 2021, meeting and asked that his name be added to the attendees listed for that meeting.

Ms. Belfi made a motion, seconded by Ms. Bernard, to adopt the Working Group’s Feb. 25, 2021 (Attachment Two-A); Jan. 28, 2021 (Attachment Two-B); Jan. 19, 2021 (Attachment Two-C); and Nov. 17, 2020 (see NAIC Proceedings – Fall 2020, Financial Condition (E) Committee, Attachment Three) minutes, with the addition of Mr. Spudeck to the attendee list for the Feb. 25 meeting. The motion passed unanimously.

2. Continued Discussion of the 2021 GCC Data Collection

Mr. Rehagen noted that a 2021 data collection is now being referred to as a 2021 Trial Implementation (Trial). He referred the Working Group’s attention to an updated data collection considerations attachment (Attachment Two-D) in the meeting materials. The document was originally presented during the Working Group’s Jan. 28 meeting. He stated that a survey was subsequently sent to all Working Group members and interested state insurance regulators. The survey posed questions related to the Trial, including selection process, submission and review deadlines, data year, and practical numbers of volunteers that could be included. Mr. Rehagen stated that 16 responses were received by the due date of March 5. He said that almost all of the responses came from Working Group members and that survey responses are reflected in the attachment.

Mr. Rehagen stated that the Purpose section at the beginning and the Related Considerations section at the end of the document reflected some of the input from the Working Group’s January meeting but otherwise have not changed much. He added that most of today’s discussion will be focused on the revisions to the other sections in the document. He then walked through each relevant issue addressed in the survey.

a. Process for Selecting Participants in the Trial

Mr. Rehagen said that based on the results of the survey, NAIC staff recommend following the same confidentiality process used for the 2019 field test and that 75% of the survey respondents supported this approach. There were no objections to this approach from Working Group members.

Mr. Rehagen said that NAIC staff could take the lead in establishing a list of potential volunteers, which then would be presented to each lead state for review and selection based on available resources. However, for the 2019 field test, potential volunteers were directed to contact their lead state to discuss participation. Ms. Belfi stated that more lead state involvement is preferred so that the number of volunteers could match resources to review submissions. She said she prefers that the canvass
letter come from the Connecticut Insurance Department. Ms. Weaver asked whether what Ms. Belfi was suggesting would
limit participation from groups that other licensed states might want to see. Ms. Malm said she has no problem with the NAIC
compiling a list as long as the state insurance regulators had the final say on which groups could participate. Lou Felice (NAIC)
confirmed that Ms. Carey’s view was consistent with the NAIC’s intent. Ms. Berry stated that some groups want all contact to
go through the Illinois Department of Insurance (DOI) rather than directly to the NAIC. Mr. Schrader agreed that the lead state
should do the actual canvass for participants. Ms. Carey asked how the number of participants accepted by all lead states would
match NAIC resources available to assist in the review of Trial submissions. Mr. Felice stated that most states responding to
the survey indicated they could handle between two and four volunteers and that the NAIC could handle roughly 30 participants.
He said that the NAIC could also provide limited assistance for additional participants that do not want the lead state to share
data with the NAIC. Mr. Wolf noted that NAIC resources should prioritize internationally active groups that also participate in
the insurance capital standard (ICS) aggregation method (ICS-AM) data collection exercise conducted by the International
Association of Insurance Supervisors (IAIS).

In response to a question from Ms. Berry, Mr. Rehagen stated that the Trial would be open to groups beyond those who
participated in the 2019 GCC field test depending on the resource capacity of each lead state.

Mr. Rehagen summarized the discussion by stating that he would work with NAIC staff to draft wording for a canvass letter
that would then be sent by each lead state to select groups. The Working Group members agreed. Mr. Rehagen directed NAIC
staff to draft the language and present it to him for review.

b. Due Date for Submissions and Data Year

Mr. Rehagen said that a majority of state insurance regulators responding to the survey supported starting the review of
submission in June 2021 and that almost all state insurance regulators responding to the survey supported a default date for

Thomas Finnell (America’s Health Insurance Plans—AHIP) asked about shadow submission from groups not participating in
the Trial but wanting to complete the GCC templates, specifically with regard to submitting questions as part of question-and-
answer (Q&A) guidance published. Ms. Belfi said she supports involvement of such groups in the Q&A process. Mr. Felice
stated that the NAIC would address questions from nonparticipants but suggested that all questions come through the group’s
lead state rather than directly from the group.

Mr. Finnell, Keith Bell (Travelers Insurance) and Maria Gomez-Vock (American Council of Life Insurers—ACLI) expressed
concern about groups’ ability to submit the Trial template with 2020 data by the end of June. Ms. Gomez-Vock also asked
about the timeline for the 2021 ICS-AM data collection. Ned Tyrrell (NAIC) stated that the submission will be due at the end
of August using 2020 financial data. Ms. Gomez-Vock suggested an August submission date for the Trial template. Mr. Wolf
stated that the Trial submission should be received before the ICS-AM data in order to allow the NAIC sufficient time to review
the Trial submission and provide feedback prior to the states reviewing the ICS-AM submission. Ms. Berry and Ms. Belfi
agreed. Ms. Malm asked if an August submission date would leave enough time to complete the review and have a report by
the Fall National Meeting. Ms. Mears asked if the June deadline could be retained but extended by the lead state based on
requests by a participating group.

Mr. Rehagen asked if the Working Group prefers a fixed July 31, 2021, submission deadline or Ms. Mears’ suggestion. Ms.
Belfi expressed support for a fixed July 31 submission date. Mr. Wolf and Mr. Eft agreed. Mr. Rehagen asked if the Working
Group members agreed with a July 31 submission deadline for the Trial template using year-end 2020 data. There were no
objections.

In response to a question about when the GCC would become effective, Dan Daveline (NAIC) stated that adoption into a state’s
law would govern. However, it was not expected that such legislative action would occur in 2021. So, for most states, the GCC
would most likely be effective for year-end 2022.

c. End Date for Review of Submissions

Mr. Rehagen said that about half of state insurance regulators responding to the survey thought the review should be completed
by October. Some suggested earlier, and a few later. Mr. Rehagen expressed support for an October time frame as reasonable
in order to possibly have results compiled and discussed by the Fall National Meeting.
d. Stress Tests

Mr. Rehagen stated that the data considerations attachment also included initial thoughts on stress testing that could be added to the Trial template. He asked for some initial feedback. Mr. Finnell stated that scenario testing might be overly complex for health groups. Mr. Bell stated that there are unique stresses for property/casualty (P/C) groups. Ms. Gomez-Vock suggested referring the stress testing issue out to a study group made up of state insurance regulators and industry representatives. Mr. Felice stated that the Trial stresses were intended to be used for the purpose of evaluating unintended consequences but not generally as permanent additions to the GCC template. Mr. Rehagen agreed. Mr. Finnell supported Ms. Gomez-Vock’s comments and suggested taking the issue offline for further detailed discussion.

3. Discussed Other Matters

Mr. Finnell repeated a prior request that the GCC instructions be edited for increased clarity. Mr. Felice stated that NAIC staff are completing edits, which will be presented during a future Working Group meeting. In response to a question from John DuBois (MassMutual), Mr. Rehagen clarified that the Working Group supports a July 31 Trial data submission deadline and a completion date of Oct. 31 for the review of the submissions.

Having no other business, the Group Capital Calculation (E) Working Group adjourned
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met Feb. 25, 2021. The following Working Group members participated: John Rehagen, Chair (MO); Kathy Belfi, Vice Chair, and John Loughran (CT); Susan Bernard (CA); Kevin Clark (IA); Ray Spudeck (FL); Susan Berry (IL); Roy Eft (IN); Christopher Joyce (MA); Judy Weaver (MI); Kathleen Orth (MN); Jackie Obusek (NC); Justin Schrader (NE); Bob Kasinow (NY); Dale Bruggeman and Tim Biler (OH); Greg Lathrop (OR); Melissa Greiner and Kimberly Rankin (PA); Trey Hancock (TN); Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI). Also participating were: Johanna Nickelson (SD); and David Provost (VT).

1. Adopted Recommendations to the Financial Condition (E) Committee Regarding Accreditation

Mr. Rehagen described the materials for the meeting, including the comments (Attachment Two-A1) received and the exposed recommendations and related memorandum.

a. Expeditious Adoption of Standards

Mr. Rehagen described some of the comments received related to the issue of the expeditious adoption of the standards. He said there was a suggestion in the cover memorandum to the draft memorandum to the Financial Condition (E) Committee that, similar to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) adopted in 2019, the Working Group would propose a waiver of the procedures in terms of normal timelines at the Financial Regulation Standards and Accreditation (F) Committee to allow the group capital calculation (GCC) to be adopted prior to the Nov. 7, 2022, date for the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement). Mr. Rehagen pointed out that after reviewing the comments, NAIC staff are now suggesting the Working Group consider a “bifurcated” accreditation due date to allow states that do not have a U.S. group subject to the covered agreement to adopt the model under a more normal timeline. He noted that NAIC staff have also suggested the Risk Retention Group (E) Task Force be given more time to determine its own standard for risk retention groups (RRGs) as long as it does not contradict that the NAIC needs to have all states that have groups that are subject to the EU Covered Agreement to have the model in place by the Nov. 7, 2022, date.

Marianna Gomez-Vock (American Council of Life Insurers—ACLI) stated that the ACLI continues to feel strongly that the standards need to be in place by the EU Covered Agreement date, which would be essential for those who supervise groups subject to that agreement. She said the ACLI would also feel more comfortable if it was for all states as opposed to the bifurcated approached, in part because what would occur if a group were to have its business changed to where it had a new group-wide supervisor in a state that would not have otherwise passed the model. She stated she believes that complication raised issues that should be considered. Mr. Rehagen agreed and stated he believes the state would have to adopt the model and noted that he believes the state would want to do so. Ms. Gomez-Vock stated the ACLI does not have an opinion on RRGs.

Bob Ridgeway (America’s Health Insurance Plans—AHIP) stated that AHIP thinks if state insurance regulators believed this was a critical issue to shorten the normal accreditation timeline, then AHIP asks that the circumstances that justify that shortening of the period be set out clearly in the referral memorandum. He stated that the accreditation program has worked well and that everything should be done to retain its high standards and noted nothing should be done in casual manner. Mr. Rehagen asked Mr. Ridgeway if he has considered the revised language in the memorandum that contemplates a bifurcated timeline and noted that even if he had not, this referral will next be considered by the Financial Condition (E) Committee. Therefore, there may be an opportunity for further changes to the language to the memorandum to the Financial Regulation Standards and Accreditation (F) Committee. Becky Meyer (NAIC) stated that any consideration of shortening the normal
accreditation timeline would require a two-thirds majority vote and, therefore, is considered very carefully. Mr. Ridgeway stated that he is most interested in the documentation of the reason and not just the vote since the documentation will last.

Jonathan Rodgers (National Association of Mutual Insurance Companies—NAMIC) asked if the accreditation program would run on two separate tracks if the bifurcated approach were adopted. Ms. Meyer asked Mr. Rodgers if he were asking whether this pertains to when the Financial Regulation Standards and Accreditation (F) Committee were to consider adoption if it would be two different tracks. Mr. Rodgers clarified his question by asking if this would be an accreditation standard for all states or only those states that are affected by the EU Covered Agreement. Ms. Meyer responded that the current memorandum suggests the intention is it would be an accreditation standard for all states. However, with the bifurcation method, if implemented, some states would be required to implement the standard earlier in accordance with the EU Covered Agreement time frame, but all states would eventually be required to adopt the language. Ms. Gomez-Vock asked the circumstances of a state that has an internationally active insurance group (IAIG) and the efforts at the International Insurance Relations (G) Committee to obtain comparability for the aggregation method with the insurance capital standard (ICS). Mr. Rehagen stated that he believes so, noting that he believes states with IAIGs would consider. Ms. Meyer clarified that the task before the Working Group is to make a recommendation to the Financial Regulation Standards and Accreditation (F) Committee and to include enough information for it to make such a decision. Mr. Rehagen stated that unless Working Group members disagree, he believes it is appropriate for the Working Group to move forward with the bifurcated approach as documented. Ms. Nickelson requested additional information be added to the memorandum to describe the reason for proposing the GCC as an accreditation standard for all states. Mr. Rehagen stated he believes the letter already described the reason. However, Dan Daveline (NAIC) suggested further language could be added.

b. Requirements for Groups Not Operating Internationally

Ms. Walker stated Texas has been consistent in its view that this standard should be applicable to those groups subject to the EU Covered Agreement. Mr. Ridgeway noted AHIP supports the Texas suggestion. Ms. Gomez-Vock stated the ACLI is strongly opposed to the Texas suggestion and strongly supports the suggestion by the NAIC that no change should be made on the basis that the GCC was developed as a tool to help with the group supervision of all groups and not just those that have international operations.

c. Subgroup Reporting

Ms. Walker said there was an issue as the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) were being finalized. The phrase for “ensuring competitiveness of the insurance marketplace” was one whose terms did not align with the terms of the EU Covered Agreement, and she requested it not be included in the accreditation standard. Ms. Belfi stated that she would like to hear more from interested parties on whether that language needs to be included and noted that some members of the industry said they did not think it was necessary. Kim Welsh (Reinsurance Group of America—RGA) noted that RGA weighed in early and believes it needs to be in the law. She said RGA wants to make sure states have that authority and, therefore, she believes it is critical. Ms. Belfi and Mr. Rehagen clarified the question relates only to the small number of words. Ms. Welsh emphasized this is at the commissioner’s discretion, and while RGA thinks it is important, it may not consider it is at the commissioner’s discretion. Mr. Bruggeman stated he believes the language would not cause harm and that is why it was included in the model. However, he said he does not think it is necessary. Ms. Macaluso stated she does not understand why this language was being removed given it was included in the model. Ms. Belfi noted that she believes the issue that the language already includes broad language using the term “prudential oversight” and that this is sufficient, and some states have concerns with the language that is being proposed to be removed. Mr. Rehagen noted that given three states are not opposed to taking it out, the Texas suggestion to remove this phrase would be taken out.

d. Concurrently File the GCC With Form B

Ms. Berry asked if the date could be similar to the Own Risk and Solvency Assessment (ORSA) and, therefore, be different from one group to the next. Mr. Rehagen stated the due date could be different from state to state, but the state should set it—not the company. Mr. Bruggeman noted the due date should be set by the lead state, and concurrently the file may not work with an early due date. As such, he stated he supports the recommendation.
e. Confidentiality Requirements

Mr. Rehagen noted the accreditation requirement of “substantially similar” applies to the entire model, but that “similar” was used for the individual elements so that some are not reinforced more than others. He noted that if some of the individual elements indicate “substantially similar,” those should be modified. Ms. Gomez-Vock stated they support the NAIC staff recommendation with the proposed change from what was originally exposed, with the understanding that Mr. Rehagen just noted. Ms. Meyer stated she agrees with Mr. Rehagen. She noted that that the approach used for the ORSA is the same structure and is the correct way forward, and she said she appreciates working through the language together. Mr. Ridgeway noted that confidentiality hit a nerve. He said the states may adopt different language where the careful language is eroded, and those words have meaning, which is troubling. He stated they were trying to change that trend. He noted that if “substantially similar” is a higher standard, it should be followed, and he suggested if it were up to him, the language should have to be the same or as close to the same from state to state or from model to model. Dan Schelp (NAIC) stated he believes there was a misunderstanding. Specifically, states are required to adopt Model #440 or substantially similar to Model #440. As a matter of style, in the significant elements, similar is indicated, but they are are being looked at in a substantially similar threshold.

Ms. Belfi made a motion, seconded by Ms. Walker, to adopt the revised recommendations memorandum and revised standards, with modifications to incorporate language to address the comments from South Dakota, and send to the Financial Condition (E) Committee. The motion passed, with Virginia abstaining.

2. Adopted a Recommendation to the Financial Condition (E) Committee Regarding a New Charge

Mr. Rehagen said that included in the materials was a recommendation to the Financial Condition (E) Committee to create a group to address the GCC’s recognize and accept concept that was built into Model #440 and Model #450. He stated that in 2020, he suggested it be the same group as the Qualified Jurisdiction (E) Working Group, and the memorandum makes that recommendation. He also recommended that the Working Group be moved from under the Reinsurance (E) Task Force and report directly to the Financial Condition (E) Committee. He stated he believes the idea is that once the Working Group developed the process, it would also maintain the two listings contemplated in Model #440 and Model #450.

Mr. Schrader made a motion, seconded by Mr. Lathrop, to adopt the recommendations. The motion passed unanimously. Having no other business, the Group Capital Calculation (E) Working Group adjourned.
Re: NAIC Group Capital Calculation Exposure Memo (dated Jan. 19, 2020) to the E Committee regarding accreditation standards for the 2020 revisions to the Insurance Holding Company System Model Act (#440) and Insurance Holding Company System Model Regulation (#450).

Dear Mr. Rehagen,

The ACLI appreciates the opportunity to respond to the NAIC Group Capital Calculation (“GCC”) working group’s exposed memo to the NAIC “E” Committee (dated January 19, 2021). The memo addresses the GCC working group’s proposed accreditation standards for the 2020 revisions to incorporate the GCC into the Insurance Holding Company System Model Act (#440) and Insurance Holding Company System Model Regulation (#450).

ACLI supports the waiver of procedure & expeditious adoption of the standards.

ACLI strongly supports the memo’s recommendation that the F Committee should consider a waiver of procedure, as provided for in the Accreditation Program Manual and expeditiously consider adoption of the GCC-related standards, so they become effective by November 7, 2022. We encourage the NAIC, as a standard setting body, to actively communicate the importance and consequences of the November 7, 2022 deadline, to the regulatory community. As the memo correctly notes, the deadline is especially consequential for lead-state regulators who supervise insurance entities or groups that operate in the E.U. or U.K. Those states have a very limited amount of time to pass the revisions. ACLI has launched initial outreach efforts to discuss the 2020 amendments to the Holding Company Act, and we are ready and willing to assist with the timely passage of these important amendments.

ACLI recommends changing the filing period to “annual” instead of “concurrently” with Form B.

ACLI recommends a minor change to the accreditation standard for the filing requirements for the group capital calculation. We recommend replacing “shall concurrently file with the registration and annual group capital calculation” with “shall annually file a group capital calculation” in item (l)(i). This would ensure states
and the respective insurance groups they supervise have sufficient time to develop and aggregate the information needed to complete the GCC filing (e.g., final year-end statutory results for subsidiaries, international affiliates, etc., some of which would not be available until after the registration is filed).

**ACLI supports the adoption of “substantially similar” confidentiality provisions.**

The confidentiality of the GCC (and the Liquidity Stress Test) calculation, including group capital information shared by the Federal Reserve or international regulators, is highly important to our members. The memo’s proposed list of “significant elements” of the 2020 revisions to the Model Act and Regulation includes one confidentiality-related element, item “m”, which prohibits insurers from sharing information about the GCC or LST to advertise. ACLI supports the inclusion of this section in the standards, but we believe additional significant elements are warranted.

ACLI strongly prefers that the significant elements for accreditation incorporate all substantive revisions made to section 8G. At a minimum, the significant elements should also include these items:

- Provisions for maintaining the confidentiality of GCC (or Liquidity Stress Test) materials submitted to the Department (section 8A(1))
- Provisions for information sharing agreements that maintain the confidential and privileged status of the documents (section 8C(4)(a))

Similar confidentiality protections, such as the Own Risk Solvency Act (#550) are already afforded status as “significant elements” of the “substantially similar” accreditation status. Given that most states have already enacted similar confidentiality provisions for ORSA materials – it is reasonable to expect the same levels of confidentiality for the GCC and LST related materials.

**Conclusion**

Thank you for the opportunity to share our comments on the exposed memo to the E Committee. ACLI always appreciates the chance to engage with the Working Group on this important issue. If you have any questions or concerns about our comments, please feel free to contact me. We look forward to continuing to work together in the future.

Sincerely,

Mariana Gomez

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1. This section inadvertently referred to section 8G. The intent was to state our belief that all material changes to section 8 should be included in the standards, and the standards should not be limited to amended section 8G.
2. Similarly, we believe that is equally important to deem section 8A(2) a “significant element.” Section 8A(2) protects the confidentiality of liquidity stress test results and data.
3. The final accreditation standards for the 2020 revisions should also include significant elements that are LST-related, including, but not limited to: (i) a provision exclude materials or information collected through the liquidity stress test from being stored in a permanent database once the initial analysis is completed; and (ii) provisions requiring notification and identification of third-party consultants who will receive LST materials.
4. The significant elements from the Own Risk Solvency Assessment (#505) accreditation standard require states to: “Include substantially similar provisions for protecting confidential information submitted to the commissioner, including provisions maintaining confidentiality for information shared with state, federal and international regulators. If sharing confidential information with the NAIC and third-party consultants is permitted, appropriate confidentiality protections should be included.”

https://content.naic.org/sites/default/files/inline-files/committees_f_orsa_significant_elements.
January 25, 2021

VIA EMAIL (ddaveline@naic.org)

Dan Daveline
Director – Financial Regulatory Services
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-219

Re: Draft Memorandum from Group Capital Calculation (E) Working Group to Financial Condition (E) Committee

Dear Mr. Daveline:

Liberty Mutual strongly supports your draft memorandum and its recommendation that the 2020 amendments to the Insurance Holding Company System Model Act (#440) and Insurance Holding Company System Model Regulation (#450) become accreditation standards.

Liberty Mutual has been an early and stalwart advocate of the NAIC’s now fully developed and adopted Group Capital Calculation (GCC). As the memo points out, “the GCC will serve as an additional financial metric that will assist state insurance regulators in identifying risks that emanate from a holding company system.” Importantly, the GCC is the result of years of careful and responsible regulatory study and analysis during a process that offered ample opportunity for all interested persons to express their views and participate in its development.

As the memo correctly notes, action on the GCC is needed more today than when the NAIC began its development. It should become an NAIC accreditation standard because uniform adoption of the GCC across the states is crucial so that the U.S. can meet its obligations under its Covered Agreements with the EU and the UK. Moreover, the GCC will form the basis for the U.S. to assert that it has developed an Aggregation Method that is comparable with the Insurance Capital Standard being finalized by the IAIS. This outcome is essential in order to ensure our strong and competitive insurance market is not materially weakened by the ICS.

In summary, we urge the NAIC to move promptly to adopt the GCC as an accreditation standard and stand ready to assist in achieving that objective.

Very truly yours,

Edmund C. Kenealy

Liberty Mutual Group
Helping People Live Safer, More Secure Lives
February 9, 2021

John Rehagen  
Chair, Group Capital Calculation (E) Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106

VIA Email Transmission: ddaveline@naic.org; lfelice@naic.org

RE: NAMIC Comments on January 19, 2021 Memorandum to Financial Condition (E) Committee

Dear Chair Rehagen:

The following comments are submitted on behalf of the member companies of the National Association of Mutual Insurance Companies1 regarding the recommendations included in a memo dated January 19, 2021 from the NAIC Group Capital Calculation (E) Working Group to the Financial Condition (E) Committee.

The memorandum details several recommendations by the GCCWG for the E Committee to consider including a recommendation that all states that are the lead state for a group subject to the Group Capital Calculation should be required to adopt the revisions to the Insurance Holding Company System Model Act (#440) and Insurance Holding Company System Model Regulation (#450) by November 22, 2022. The memo further states that the new “significant elements” included as an appendix to the memo should apply to all states and be adopted by NAIC-accredited jurisdictions in a substantially similar manner. The GCCWG is also recommending the E Committee consider supporting a waiver of procedure to expeditiously consider adoption of the recent changes to the models that include the new GCC as an accreditation standard. Our comments will be limited to these three issues: timing for states to adopt, significant elements, and the requested waiver of procedure.

Timing

1 NAMIC membership includes more than 1,400-member companies. The association supports regional and local mutual insurance companies on main streets across America and many of the country’s largest national insurers. NAMIC member companies write more than $278 billion in annual premiums. Our members account for 58 percent of homeowners, 44 percent of automobile, and 30 percent of the business insurance markets. Through our advocacy programs we promote public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.
NAMIC understands the importance of states complying with the requirements under both the Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance as well as the similar agreement between the U.S. and U.K. (Covered Agreements). However, it appears there is a gap in understanding about the application of the group supervision requirements included in the Covered Agreements and a question about the Federal Insurance Office’s preemption authority in this regard. We agree that the FIO was granted preemption authority over state laws that do not conform to the terms of the negotiated Covered Agreements as defined and provided for under the Dodd-Frank Act. And as it applies to reinsurance, the preemption authority is clear to us that any laws that would still require reinsurers to post collateral in the US would likely be stricken down. Where it is not entirely clear is whether the Covered Agreement’s preemption authority extends to the creation/absence of a group capital requirement.

We suggest that the NAIC authorize a third-party legal analysis of the Covered Agreements preemption authority to determine if and how that applies to the GCC. Given the differences in interpretation, NAMIC members do not agree with the aggressive timeline for all states to adopt the changes to Model #440 and #450 as suggested in the memo. It is our understanding that U.S. groups with no operations in the EU or UK should not be impacted by the Covered Agreements. It does not appear to our members that the Covered Agreements would even apply to territories outside of the US and EU or US and UK. As such, a group that is not actively operating insurance activities in the EU or UK would not need to be regulated under a group supervision scheme designed for the Covered Agreements purposes.

The NAIC has completed its work on developing a group capital calculation. As states begin to consider the changes to the models, it is worth reviewing the stated purpose of the Covered Agreements. That is to create mutual acceptance of regulatory supervision of entities operating in both parties’ territories in order to remove duplicative regulatory supervision of those entities. It is important to not lose sight of the intent of these Covered Agreements. As far as group supervision, a US group with no operations in the EU/UK should not be impacted by the Covered Agreements. For these reasons, we suggest a comprehensive review of FIOs preemption authority.

**Significant Elements**

The revisions to Models #440 and #450 include a new requirement for insurers in a holding company structure to file an annual GCC. This new requirement was developed largely to enhance group supervision capabilities and to quantify risk of insurance entities and their affiliates that may be exposed to risk from other entities in a large and complex holding company. While the calculation was developed to apply to complex entities and internationally active groups, the model law revisions include certain exemptions for single-state, single-insurer holding companies, groups required to perform a group capital calculation for the Federal Reserve Board, and certain internationally active insurers operating in Reciprocal Jurisdictions. These provisions are included as significant
elements and are being recommended as required provisions in order for states to maintain accreditation status with the NAIC. In addition to these exemption provisions, it is also recommended that states adopt the confidentiality provisions prohibiting the making, publishing, disseminating, circulating, or placing before the public the GCC or resulting GCC ratio in a substantially similar manner. NAMIC members agree with the inclusion of these significant elements as part of the Accreditation procedures.

Additional flexibility for the regulator is needed for the GCC.

As it applies to the significant elements included as part of the Model Act (#450), NAMIC members recommend the NAIC defer the inclusion of the Model #450 significant elements until regulators have had a chance to review the initial batch of GCC results. This would not impede states ability to adopt the model law changes or from insurance departments from implementing the changes to the model regulation but would give insurance departments more flexibility and time to consider the impact of the GCC, without having to adopt a regulation that provides little flexibility.

Regulatory discretion is already baked into the model law and regulation. Nearly every state that previously adopted the holding company act has the general authority to exempt a company from any or all of the provisions of the HCA registration requirements. It is part of the model law adopted by the NAIC and already made an accreditation standard. It is part of the flexibility that the NAIC intended to give regulators. Given that most all holding companies will be required to file at least one GCC, state insurance regulators should have an opportunity and time to determine the usefulness and value the GCC provides them for the domestic insurers they regulate.

**Accreditation Waiver of Procedure**

Given our objection to the aggressive timeline for all states to adopt these standards and our request for an independent third-party assessment of FIO’s preemption authority in regard to the GCC, NAMIC members do not agree that the F Committee should waive any procedures that would avoid seeking public input on these important changes to the Financial Regulation Standards and Accreditation Program. Historically when changes are made to solvency standards and those changes are considered for accreditation purposes, a set schedule of events are established in a deliberative process for interested parties to understand how/when key decisions will be made. It appears to us that the NAIC is suggesting waiving that process altogether and deeming the recent changes to the holding company models already accreditation standards. There is no need to rush the Accreditation process, particularly when you have states introducing and adopting credit for reinsurance legislation, an accreditation standard that went through the Accreditation approval process. In the meantime, it is more important to address some of these unanswered questions and to support impacted lead-states on adopting the changes to the model law. Therefore, NAMIC suggests that these proposed changes to the Accreditation
standards go through the normal 12-month approval process, including exposing for comment the significant elements included in the memo.

We appreciate the opportunity to take part in the process. Thank you for your consideration of these comments on this matter of importance to NAMIC, its member companies and their policyholders. If there are any questions, please feel free to contact me at 317-876-4206.

Sincerely,

Jonathan Rodgers
Director of Financial and Tax Policy
National Association of Mutual Insurance Companies
February 9, 2021

John Rehagen, Chair
Group Capital Calculation (E) Working Group

Dear Mr. Rehagen:

Texas appreciates the opportunity to provide comments on the exposed recommendation to the Financial Condition (E) Committee regarding accreditation standards associated with the group capital calculation (GCC) amendments to Models 450 and 460. Our comments are as follows:

Exposed:

i. Filing requirements for the group capital calculation filing similar to those specified in Section 4L(2) of Model #440?

   i. The ultimate controlling person of every insurer subject to registration shall concurrently file with the registration and annual group capital calculation completed in accordance with the NAIC Group Capital Calculation Instructions as directed by the lead state commissioner similar to section 4L(2)?

n. Filing requirements for the group capital calculation filing similar to those specified in Section 21 of Model #450?

   i. Provision that gives the lead state the authority to exempt the filing of the group capital calculation provided the criteria are substantially similar to those allowed under Section 21A of Model #450?

Comments:

Texas is opposed to the broad requirement that every group file a GCC as an accreditation requirement. The accreditation standard to file a GCC should be limited to those with international operations and provide the lead state commissioner the discretion to require any group file a GCC.

A state’s accreditation status should not be threatened if all groups are not required to file the GCC once. As currently contemplated, if all groups are required to seek an exemption from the lead state commissioner annually, valuable resources that could be used to monitor solvency will be used in a bureaucratic process that does not enhance
solvency oversight of companies. Insurance department staff are already receiving ORSA filings, Form Bs, and Form Fs and have been completing group analyses for several years. The added filing of the GCC should only be required in situations where the lead state commissioner believes that it would add valuable insight and information to group oversight, not just because it is an accreditation requirement.

Through the supervisory college framework, other regulators would be able to raise concerns about a group's operations and discuss whether a GCC should be required. Because this approach would “achieve the objective of the standard,” this approach should be accepted as substantially similar in effect.

Additionally, Texas is supportive of modifying this standard to generally refer to the filing of the GCC annually and not tie that filing to submission of the registration statement. In Texas the registration statement is due on April 1 each year, but the consolidated independent audit report of a group may not be completed by that time. Therefore, the GCC filing would be diminished in value. The lead state commissioner should have the discretion to determine the timing that would yield the most valuable information in situations where a GCC is required.

Exposed:

vi. Provision that gives the lead state the authority to require the GCC for U.S. operations of any non-U.S. based insurance holding company system where after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace, substantially similar to 4L(2)(e)?

Comments:

Texas recommends deleting the phrase “for ensuring competitiveness of the insurance marketplace” from the accreditation standards because this phrase is not found in the covered agreement. We worry that a regulatory decision that relies on this language risks triggering scrutiny by the Joint Committee established under the covered agreement. Additionally, this provision does not promote sound insurance company financial solvency regulation which is the mission of the Accreditation Program. There are other avenues for addressing concerns with international jurisdictions.
Conclusion:

Texas opposes requiring GCC filings to be prepared by groups and reviewed by insurance departments when the filing is not needed to understand group operations. A state’s accreditation should not be affected if:

- the state enacts a GCC law that requires filings from all groups with international operations and provides the lead state commissioner discretion to require all other groups file and
- aligns with the language included in the covered agreement.

In closing, Texas also suggests consideration be given to whether the accreditation standard applies to all states or a subset of states where the GCC will be more meaningful. As proposed, Texas sees no reason to apply this standard to all states, some of whom have a limited number of non-complex groups and are already receiving sufficient information via the other form filings. An all-state accreditation standard aligned with Texas’ suggestions, however, could be more useful as it would give a lead state commissioner the authority to require a GCC if needed, but not require a filing.

Thank you for the opportunity to provide these comments.

Respectfully,

Jamie Walker
Deputy Commissioner
February 9, 2021

Mr. Dan Daveline
Director, Financial Regulatory Services
Group Capital Calculation (E) Working Group
National Association of Insurance Commissioners

RE: GCC Recommendation to E committee with respect to accreditation standards related to 2020 Revisions to Insurance Holding Company System Model Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)

The Vermont Department of Financial Regulation – Captive Insurance Division (VT DFR) appreciates the opportunity to comment on the GCC Working Group’s recommendation to E Committee regarding the appropriateness of the GCC with respect to accreditation standards. The VT DFR has concerns about broadly applying an accreditation standard for GCC to all risk retention groups within a holding company system and respectfully requests additional time to consider appropriate ways to include, exclude, or develop iterations specifically for risk retention groups given their unique structure. Thank you for your consideration.

Sincerely,

Christine Brown, Assistant Director
Captive Insurance Division

cc: David Provost, Deputy Commissioner of Captive Insurance – VT DFR
    Sandy Bigglestone, Director of Captive Insurance – VT DFR
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met Jan. 28, 2021. The following Working Group members participated: John Rehagen, Chair (MO); Kathy Belfi, Vice Chair (CT); Susan Bernard (CA); Philip Barlow (DC); Carrie Mears (IA); Susan Berry (IL); Roy Eft (IN); Christopher Joyce (MA); Judy Weaver (MI); Fred Andersen (MN); Jackie Obusek (NC); Justin Schrader (NE); Dave Wolf (NJ); Bob Kasinow (NY); Dale Bruggeman (OH); Greg Lathrop (OR); Melissa Greiner and Kimberly Rankin (PA); Trey Hancock (TN); Mike Boerner (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. **Heard a Presentation on Data Analysis for the Adopted GCC Template Using 2019 Field Test Data**

Mr. Rehagen stated that NAIC staff have completed a high-level analysis and comparison of the impact of data collected during the 2019 group capital calculation (GCC) field test, and after applying that data in the adopted GCC template. He asked Lou Felice (NAIC) to present the information.

Mr. Felice described the various manners in which the data was compiled and presented to compare the GCC ratio resulting from the field test with that resulting from the adopted GCC template and presented the results of the analysis (Attachment Two-B1). That data included:

- Overall GCC ratio.
- Impact of excess relative ratio scalars applied to foreign insurers.
- Impact of debt allowed as additional available capital.
- Impact of adjusting level of risk for asset managers.
- Impact of applying alternative “sensitivity analysis” capital calculation to non-insurance/nonfinancial entities.

Mr. Felice provided some initial observations and limitations on how the data was translated from the field-testing template to the adopted template. He concluded with NAIC staff recommending supporting further data collection in 2021. Mr. Rehagen then asked for comments or questions. Mr. Rehagen asked about three volunteers that were excluded from the analysis. Mr. Felice indicated that only one was excluded due to quality of the data. The others were excluded due to their insurance operations being either non-risk-based capital (RBC) or an unusual business profile where noninsurance financial activities outweighed insurance operations. Tom Finnell (America’s Health Insurance Plans—AHIP) suggested use of de-identified scatter charts with plotting boxes. Mr. Felice said he thinks that is a good idea but might be better when there are more data points for the various group types and business lines. David Neve (Global Atlantic Financial Group—Global Atlantic) asked if the GCC ratio for health insurance groups was higher than for life insurance groups. Mr. Felice confirmed that to be true. Mr. Neve then asked why health insurance group aggregated data was not shown separately in the analysis. Mr. Felice noted that the data was driven by two large health insurers and that there were a small number of health insurance groups that volunteered, so presenting the data could be problematic.

2. **Discussed Future Data Collection**

Mr. Rehagen stated there are some outstanding issues, such as awaiting a report from the American Academy of Actuaries (Academy) regarding foreign insurer scalars. He noted the NAIC staff recommendation to conduct further data collection in 2021. Mr. Rehagen then asked for comments on data collection and that of several interested parties had made prior comments in support of further GCC data collection in 2021. He added that he had reached out to several of those commenters and that some of their comments resulted in discussion points (Attachment Two-B2). The points included purpose and data/timing for a potential 2021 data collection.

Marianna Gomez-Vock (American Council of Life Insurers—ACLI) stated support for data collection and using March 2021 data to evaluate stress on the GCC ratio. Mr. Finnell stated that a March 2021 cutoff could be burdensome and that the stresses and the duration of those stresses related to COVID-19 could vary by insurer type. He said that adding clarity to the instructions and template should be part of the key points.

Mr. Rehagen then highlighted the potential range of methodologies for conducting a 2021 data collection. Some would fully involve the NAIC and others would limit NAIC involvement. Mr. Finnell supported an expansion of the prior field test process on a voluntary basis. He stated that a mandatory data call should be avoided. Mr. Neve agreed and said he supports NAIC involvement to aggregate data and present results. Jonathan Rodgers (National Association of Mutual Insurance Companies—
NAMIC) agreed and asked if the discussion points document would be exposed for a public comment period. Mr. Rehagen stated that the document would be updated and may be exposed during a future meeting after further discussion. Ms. Belfi agreed with expanding the prior field test approach with NAIC participation, and she echoed concerns about the impact of COVID-19-related stresses being different across insurance lines of business. Mr. Schrader stated that it would be helpful to use the data collection to take the opportunity to improve the instructions and template. He added it would also be helpful to work with groups to assure good reporting. He stated that using calendar-year data would be preferrable to interim data. Mr. Felice stated that participation could be increased via a voluntary participation outside an expanded field-testing method for those groups that are uncomfortable with sharing data with NAIC. NAIC staff could still assist by answering questions raised by those groups or the lead-state reviewer. Mr. Rehagen agreed that would be a good way to further expand participation in the data collection.

Mr. Rehagen stated that other considerations included coordination with RBC and review and validation, which will be part of separate state insurance regulator guidance being developed by an ad hoc group of state insurance regulators and interested parties.

Mr. Rehagen reminded all participants that an initial draft recommendation of an accreditation standards document was previously exposed for a public comment period ending Feb. 9. He said a meeting will be scheduled to go over comments received.

Having no other business, the Group Capital Calculation (E) Working Group adjourned.
Data Breakouts

• Data Excluded for 3 Volunteers

• Company Type Breakouts
  ➢ Line of business
  ➢ Mutual vs. stock

• Ratios Presented
  ➢ Adjusted field test ratio (300% calibration)
  ➢ Adopted GCC ratio (200% calibration)
  ➢ Adopted GCC ratio sensitivity at 300% calibration

• Impact of XS Relative Ratio Scalars on Ratios
• Impact of Debt Allowance on Ratios
• Impact of Sensitivity Method on Non-financial Entities
Inputs

• Field Test Presented With the Following Adjustments
  ➢ Included entities only
  ➢ Debt included at 30% / 15% for senior and hybrid Debt
  ➢ Debt limited to 100% of available capital and 100% of debt
  ➢ Base capital charges
  ➢ Foreign insurers unscaled

• No changes to entity categorization from Field Test to Adopted GCC

• Adopted GCC (Unscaled Foreign insurer and Bank Capital Requirements Held Constant at all Calibration Levels)
  ➢ Asset managers assumed at high risk
  ➢ Other financial entities assumed at medium risk
  ➢ Alternative GCC Results with asset managers assumed at medium risk shown separately
Overall Ratios - LOB

Composite PC Life

GCC

Comparative Results

GCC

@200%

FT

GCC Adj.

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Overall Ratios – Asset Managers at Medium Risk - LOB

Overall Ratio - Alt GCC

- Composite
- Alt GCC @ 200%
- Alt GCC @ 300%
- FT GCC Adj.
- PC
- Life

450% 400% 350% 300% 250% 200% 150% 100% 50% 0%
Overall Ratios w/ XS Relative Ratio Scalar

GCC with XSRR Scalars

- Actual GCC Ratio (2 x ACL)
- GCC Ratio @ 3 x ACL
- FT GCC Adj.
Impact of Sensitivity Analysis on Nonfinancial Entities

Increase (Decrease) in GCC Ratio Under Sensitivity Test for Non-Ins Entities

- P/C & Composite
- Life & Health
- Mutual
- Stock

25% 20% 15% 10% 5% 0% -5% -10% -15% -20% -25%
Analysis Observations

• Issues With Analysis
  ➢ Filed test categorization of other financial and non-financial entities may not align with current categorization in adopted GCC
  ➢ Risk levels selected in adopted GCC for asset managers and other financial entities without capital requirements may not align with actual risk level determined by filer.
  ➢ Potential inconsistency or misalignment between included and excluded entities
  ➢ Additional scalar options may emerge
  ➢ Limited de-stacking for mutual groups in adopted GCC

• Additional data collection is Recommended
  ➢ To be discussed by GCC WG
CONSIDERATIONS FOR 2021 GCC DATA COLLECTION

Purpose:

- Evaluate changes incorporated into the adopted GCC Template and Instructions
  - GCC Ratio and other analytics-based data
- Consider Stress Scenarios
- Evaluate potential scalar options from Academy work performed for G Committee
- Inform IAIS Work on the ICS

Data and Timing:

- 2019 Data for consistency in results
  - Most available and audited data
- 2020 Data
  - Latest data but may require later data collection
- March or June 2020 data cutoff
  - Balance sheet data reflect highest level of stress of COVID-19 Pandemic
  - Income Statement Data will need to be annualized or adjusted
  - Most related to GCC ratio rather than other analytic data

Testing Methodology Options:

- Renew Field Test confidentiality agreements with lead-States for existing volunteers
  - NAIC gets data from lead-States and assists in review
  - Can analyze data over time
- Renew Field Test confidentiality agreements with lead-States for expanded list of volunteers
  - NAIC gets data from lead-States and assists in review
  - Expands profile of Groups for evaluation and future lead-State decision making
- Lead-state data call and review with ORSA Team style review
  - NAIC staff only sees data on a case by case basis
  - Still requires confidentiality
- Lead-state data call and review
  - NAIC gets no data but is available to provide clarity and answer questions on the template and instructions
  - Provide most expansive data collection
  - Can run in parallel with other methods described above

Related Considerations:

- Evaluate potential for increased consistency between GCC capital calculations and RBC
- Review and Validation
  - Likely related to the analysis guidance that is under development
- Future Maintenance of the GCC
  - Likely similar to RBC (TBD)
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee conducted an e-vote that concluded Jan. 19, 2021. The following Working Group members participated: John Rehagen, Chair (MO); Susan Bernard (CA); Philip Barlow (DC); Carrie Mears (IA); Judy Weaver (MI); Kathleen Orth (MN); Jackie Obusek (NC); Justin Schrader (NE); Bob Kasinow (NY); Dale Bruggeman (OH); Greg Lathrop (OR); Melissa Greiner (PA); Trey Hancock (TN); David Smith (VA); and Amy Malm (WI).

1. Exposed Proposed Accreditation Standards for the Group Capital Calculation

The Working Group conducted an e-vote to expose proposed accreditation standards for the Group Capital Calculation (GCC).

Ms. Obusek made a motion, seconded by Mr. Lathrop, to expose the proposed accreditation standards for the GCC. The motion passed unanimously.

Having no further business, the Group Capital Calculation (E) Working Group.
CONSIDERATIONS FOR 2021 GCC DATA COLLECTION – Updated 3/10/2021

Purpose:
- Evaluate changes incorporated into the adopted GCC Template and Instructions
  - GCC Ratio and other analytics-based data
- Consider Potential Stress Scenarios:
- Evaluate potential scalar options from Academy work performed for G Committee.
  - Update as available from G Committee.
- Inform IAIS Work on the ICS

Testing Methodology:
- Based upon the results of a survey sent to states with responses due back March 5, NAIC recommends the following:
  - The NAIC will utilize confidentiality agreements between each of the lead states and the NAIC similar to the Field Test (75% of 16 responding states supported this approach)
  - The NAIC will distribute a request for volunteers through its interested parties distribution list and would ask trade groups share with any groups they believe may have an interest.
  - Its expected more groups may want to participate in this process than the GCC Field Test but the NAIC and the states will be limited in how many participants their resources can handle in the same way as the GCC Field Test (e.g., delivery of observations and calls with the participant).
    - The first step for limiting the number of volunteers will be for NAIC staff to provide a complete list of volunteers to each of the lead states and for the lead states to indicate which of those volunteers they are willing to participate in the data collection with.
    - The survey results suggested some states were willing to handle 4-5 but more states suggested 1, 2 or 3 was more reasonable for their state.
    - Assuming the number of volunteers is high, NAIC staff will discuss with the proposed volunteer states to determine if a “lighter” touch can be used for additional volunteers as a means to reduce the required resources on the NAIC and the states. Some interest was expressed in a combination of an expanded data collection along with NAIC Q&A type assistance for voluntary filings by those groups preferring that the lead-State not share data with the NAIC.
    - Assuming there is a further need to limit, NAIC staff may ask that certain states further limit to a specific level to reach a more manageable number of volunteers.
    - 63% of responding states suggested not starting reviewing the volunteers’ data until June.
    - While there were different views on when the states need to have all of this work completed to make room for other work, October was the most common with 44% of the states, but some also preferred August and September and November.
    - Most responding states suggested a default date of 12/31/20 for the data collection but this may not be ideal given the goals of the data collection are to also consider the impact of certain “stresses” to be certain that the GCC is not too punitive in different economic situations.
    - A “dual date” can be considered, particularly for those States that can accept submissions in April or May whereby 12/31/19 data is submitted / reviewed earlier and 12/31/2020 data submitted in the September / October timeframe somewhat contemporaneously with typical ICS – AM data collection.
Process for the reviews will be similar to the GCC Field test where the NAIC gets the data from the lead-states and assist in the review.

Other Information:

- Life IPs expressed support for March 2021 cutoff to use COVID-19 as a stress.
- P&C and Health IPs and some regulators questioned whether COVID-19 posed similar stresses or timing of those stresses across insurer types.
  - One common suggestion was to use a stress(es) based on scenarios such as the impact of COVID. This could be accomplished by a two-part design:
    - First would be a set of individual stresses to the GCC. Impact on available and required capital would be calculated separately for each legal entity.
      **Example Stresses:** a decrease in interest rates, decrease in equities, increase in mortality, increase in corporate tax rate.
    - The next would be a set of scenario(s) which would combine the impact of these individual stresses. This would be calculated automatically by adding, at individually legal entity level, the impact of a set of individual stresses and then summarized into higher level groupings. A scenario may allow for additional input, as on-top adjustment, to reflect group’s response (e.g., issuance of debt).
      **Example Scenario:** A decrease in US 10-year treasury rate based on quarterly high/low from 2020 (151 basis points), with a decrease in equities of from high/low point in 2020 (33.9%) and an increase in mortality of equal to that of the impact of the Spanish flu (6.5 excess deaths per 1000).

Related Considerations:

- Evaluate potential for increased consistency between GCC capital calculations and RBC.
  - Possible referral to Capital Adequacy (E) Task Force
- Review and Validation
  - Likely related to the analysis guidance that is under development and State Department’s familiarity with the group.
- Future Maintenance of the GCC
  - Likely similar to RBC (TBD)
The Group Solvency Issues (E) Working Group met March 18, 2021. The following Working Group members participated:

Justin Schrader, Chair (NE); Jamie Walker, Vice Chair (TX); Susan Bernard and Kim Hudson (CA); Kathy Belfi (CT); Charles Santana (DE); Virginia Christy and Carolyn Morgan (FL); Kevin Clark (IA); Cindy Andersen and Eric Moser (IL); John Turchi (MA); Judy Weaver (MI); Debbie Doggett and Shannon Schmeoeg (MO); Margot Small (NY); Dale Bruggeman and Tim Biler (OH); Kimberly Rankin and Melissa Greiner (PA); Ed Buyalos (VA); and Amy Malm (WI).

1. Received a Report on Group-Related Activities of the IAIS

Mr. Schrader stated the first agenda item is to receive an update on recent International Association of Insurance Supervisors (IAIS) group-related activities. Mr. Schrader stated that he serves as the U.S. representative and vice chair of the IAIS’ Insurance Groups Working Group (IGWG). While the efforts of the IGWG have been affected by COVID-19 and in-person meetings continue to be suspended, work continues to move forward via virtual meetings.

Mr. Schrader stated the IGWG continues its work on updating the IAIS Application Paper on Supervisory Colleges (Application Paper). The IGWG will produce two separate documents: 1) a streamlined updated public version of the Application Paper focusing on cooperation among supervisors participating in supervisory colleges and other necessary information relevant to stakeholders; and 2) a member-only document focusing on implementation guidance in operationalizing supervisory college meetings. The public version of the Application Paper is expected to be consulted on this summer. The member-only document will not be subject to a public consultation.

Mr. Shrader stated the IGWG is also drafting a group-wide risk assessment framework member-only document to aid supervisors by incorporating IAIS Insurance Core Principles (ICPs) and the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) standards as objectives. However, the document will not be an authoritative source of what constitutes a supervisory risk assessment framework.

Ms. Belfi asked Mr. Schrader whether state insurance regulator practices around supervisory colleges are in line with the international best practices being developed. Mr. Schrader stated that state insurance departments appear to be conducting colleges in line with best practices and that he does not anticipate changes coming out of the IGWG work that would significantly affect college sessions being led by state insurance departments.

2. Received a Report of the Own Risk and Solvency Assessment (ORSA) Implementation (E) Subgroup

Ms. Belfi stated that the ORSA Implementation (E) Subgroup met March 10 in regulator-to-regulator session, pursuant to paragraph 6 (consultation with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings. During the meeting, Subgroup members discussed matters relating to the timely receipt and review of ORSA filings and received an update on NAIC ORSA training initiatives. The Subgroup also briefly discussed its role in ComFrame drafting work for the NAIC Own Risk and Solvency Assessment Guidance Manual (ORSA Guidance Manual), which will likely take place later this year after proposed revisions to the NAIC’s Financial Analysis Handbook are drafted and exposed for public comment.

3. Received a Status Report on ComFrame Drafting Group Efforts

Mr. Schrader stated that during its last meeting, the Working Group discussed its charge to: “Assess the IAIS Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) and make recommendations on its implementation in a manner appropriate for the U.S.” Mr. Schrader stated that during that discussion, the Working Group noted that while certain elements of ComFrame were incorporated into the 2014 revisions to the NAIC’s Model Holding Company Act (#440), there were several additions and enhancements made to ComFrame elements after that time that have not yet been addressed. As such, the Working Group asked NAIC staff to conduct an internal ComFrame gap analysis to highlight elements that might need to be considered for implementation.

Mr. Schrader stated that the results of the gap analysis indicated that many of the key elements of ComFrame, from an outcomes-focused perspective, are already incorporated into the U.S. system through recent amendments to model laws, the...
establishment of ORSA requirements and other ongoing regulatory practices. The gap analysis also noted that some of the more prescriptive elements of ComFrame do not appear appropriate for the U.S. system and are not being recommended for consideration. However, other elements of ComFrame were identified that appeared appropriate for consideration. Those elements included, among other things, the need to collect and review information at the Head of the Internationally Active Insurance Group (IAIG) level and the need to incorporate additional guidance into NAIC handbooks.

As such, Mr. Schrader noted that the Working Group decided to form three separate drafting groups to consider revisions to the NAIC’s Financial Analysis Handbook, Financial Condition Examiners Handbook and ORSA Guidance Manual as necessary to incorporate ComFrame elements deemed appropriate for the U.S. system of solvency regulation. Several states volunteered to participate on the drafting groups, and an initial drafting group meeting was held in September 2020 to discuss how to proceed. During that meeting, the volunteers determined that the Financial Analysis Drafting Group should first move forward with drafting proposed revisions as state insurance regulators expect the Financial Analysis Handbook to house the majority of ComFrame considerations.

Mr. Schrader stated that since that organizational meeting, the drafting group has met five different times to work through discussions on various ComFrame elements and draft proposed revisions to the Financial Analysis Handbook. Mr. Schrader stated that the drafting group is nearing the completion of its work and plans to refer its proposed revisions to the full Working Group for discussion and public exposure in the coming weeks. Thereafter, Mr. Schrader stated that he expects the other two drafting groups to begin their work soon, with a goal of completing all proposed ComFrame revisions by the end of 2021.

Robert Neill (American Council of Life Insurers—ACLI) asked whether the proposed revisions to the Financial Analysis Handbook would be considered ahead of the Spring National Meeting. Mr. Schrader stated that the Working Group does not plan to meet again until after the Spring National Meeting and will review the proposed revisions at that time.

4. Discussed a Referral From the 2020 FSAP

Mr. Schrader stated that the Working Group recently received a referral to consider a recommendation that came through state insurance regulator participation in the 2019/2020 Financial Sector Assessment Program (FSAP). In referring this matter to the Working Group, the International Insurance Relations (G) Committee made it clear that the Working Group is not obligated to implement the recommendation but should give it consideration before reporting back on the conclusion reached. The recommendation states:

State insurance regulators should better coordinate and leverage the expertise of teams of supervisors dedicated to financial analysis and financial examination for large insurance groups, including Internationally Active Insurance Groups (IAIGs).

Ms. Belfi stated that coordination between financial analysts and examiners continues to improve in our system, although we do operate differently than many international jurisdictions. Mr. Schrader stated that staffing for IAIG oversight is being considered as part of the ComFrame drafting work and will likely be addressed in the revisions proposed to the Financial Analysis Handbook and that the issue can be discussed in more detail at that time.

Having no further business, the Group Solvency Issue (E) Working Group adjourned.
Mortgage Guaranty Insurance (E) Working Group
Virtual Meeting
April 6, 2021

The Mortgage Guaranty Insurance (E) Working Group of the Financial Condition (E) Committee met April 6, 2021. The following Working Group members participated: Kevin Conley, Chair, Jackie Obusek and Richard Kohan (NC); Kurt Regner (AZ); Monica Macaluso (CA); Robert Ballard (FL); John Rehagen (MO); Margot Small (NY); Melissa Greiner (PA); Chris Miller (TX); and Amy Malm (WI).

1. Discussed Comments Received on the Proposed Mortgage Guaranty Insurance Exhibit

Mr. Conley said that one comment letter (Attachment Four-A) was received from the Mortgage Guarantors (MGs). He proceeded by discussing each comment within the comment letter regarding the proposed Mortgage Guaranty Insurance Exhibit (Exhibit) (Attachment Four-B).

   a. Question 1

   Mr. Conley stated that the MGs are concerned with confidentiality of the earned premium and State Regulatory Mortgage Insurance Capital Standard (SRMICS) triangles within the draft Exhibit. He commented that the Exhibit data would be collected electronically and stored within tables by the NAIC and made available to state insurance regulators.

Andy Daleo (NAIC) said that although the data is intended to be regulator-only, it is part of the financial statement, and the public could request the data. Mr. Daleo offered an example of a potential alternative approach for the data collection. He indicated that the filing for the Annual Statement Blank – Supplemental Compensation Exhibit is confidential and as a result, the data is not collected by the NAIC. He indicated that the Exhibit is provided directly to the states and that this data collection could be handled the same way.

Ms. Malm asked about the possibility of handling the data collection similar to the way risk-based capital (RBC) data is collected. Jackie Obusek (NC) commented that RBC is protected by state statute and said this data collection would require a change in state statute to protect it. She said that the entire contents of the financial statement are considered public and inquired as to whether the data collection could be done separately as a workpaper until states were able to change their statute to treat the data as confidential. Ms. Small said that in New York, an individual can request data. However, she said it will not be released unless the insurer approves its release. Ms. Small continued that a request for confidential data would need to be approved by a court subpoena, which is extremely rare.

Mr. Conley commented that he does not have a concern regarding confidentiality since it is just earned premium and SRMICS triangles. He stated that risk-in-force would be reported for the first time. He said it could provide some insight on pricing patterns and that the information would be helpful to state insurers regulators. He asked the Working Group if they have any concerns regarding the confidentiality of the data to the point of requiring special treatment of the data. Mr. Rehagen commented that since the MGs commented on the concern of confidentiality, they should provide their prospective.

Tony Shore (Essent Guaranty Inc.) commented that the MGs are comprised of public companies that make public disclosures and that this type of data is different. Mr. Conley said that a lot more public data is disclosed within the financial statements than what is being requested within the proposed Exhibit. He said that the data would be nongranular and that he does not believe any harm could be caused. Mr. Shore commented that he was encouraged by the discussion of keeping the data confidential by submission as a workpaper until it could be kept confidential by the model act.

Joy Benner (National Mortgage Insurance Corporation) said that she reiterates Mr. Shore’s comments and questioned whether requests by the public could be monitored along with details on how the data is being used. Mr. Daleo commented that there is a section of the NAIC that handles contracts and data requests and that he is confident that a biannual report to the Working Group on data requests would be possible. He added that he is not completely certain that all data requests are granted to the public. Mr. Shore commented that this type of report is not as good as keeping the data confidential and that the data being requested is more granular than the data within the financial statement.
Mr. Conley questioned the MGs about the particular harm that would be caused by including an earned premium and SRMICS triangle within the data collection. Mr. Shore commented that he would like to gather more thoughts on public disclosure from his company and the MGs and that he would get back to the Working Group. Mr. Conley commented that there is fear from state insurance regulators regarding hindering the ability to complete research due to access to data. Mr. Daleo commented that the Working Group will need to move forward in order to ensure it is included within the year-end financial statement. Further, he stated that the MGs were provided additional comment period time to adequately prepare.

Mr. Kohan asked about more detail on the type of data that is too granular within the proposed Exhibit. He stated that the data is country-wide data and that states are looking for an early indicator of potential problems. Robin Marcotte (NAIC) stated that most of the data being requested is very similar to other data being collected through other financial statement schedules. Following additional discussion, the Working Group decided to proceed with the proposed Exhibit.

b. Question 2

Mr. Conley commented that he is uncertain where SRMICS is tied to the Mortgage Guaranty Insurance Model Act (#630). Further, he indicated that the SRMICS formula will need to be provided within the exhibit instructions to allow the triangles to be filled out based on the formula but not necessarily tied to Model #630. Ms. Small stated that it would be nice to have a document that discloses the SRMICS formula, as well as any subsequent changes to the formula. Mr. Conley responded that the details of this documentation would be discussed during the Working Group’s status update on SRMICS.

c. Question 3

Mr. Conley stated that the Exhibit would be required of all companies with exposure to mortgage guaranty insurance.

d. Question 4

Ms. Malm commented that all companies with exposure to mortgage guaranty insurance should be required to file the Exhibit. Mr. Conley concurred with Ms. Malm and stated that there would also be a requirement to file the combined financial statement filing.

e. Question 5A

Mr. Conley indicated that column 1 and column 2 of the Exhibit would be reported on a direct basis, which would equate to the sum of all policies written during the 12-month period despite some not being current at Dec. 31. Mr. Conley also said to remove “Written” from the titles for column 1 and column 2. Will Meers (Arch Mortgage) asked whether column 1 would be as of year-end. He said this would be in direct relation to the SRMICS calculation, which is as of year-end. Mr. Conley stated that column 1 should reflect the original, whereas SRMICS would reflect the current, which is the year-end amount or slightly less than the original.

f. Question 5Aii

Mr. Conley stated that currently the industry reports assumed and ceded data on an accident year basis for 10 years within the Annual Statement Blank, Schedule P – Analysis of Loss and Loss Expenses. As a result, he stated that it is uncertain as to why the MGs feel the additional reporting is onerous. Mr. Meers commented that there are terminated reinsurance agreements that they no longer can access to calculate the historical cumulative paid loss on an assumed and ceded basis. Mr. Meers indicated that providing the data on the latest calendar year would be possible. Stacy Javorek (Mortgage Guaranty Insurance Corporation) stated that it would also be problematic to provide the historical cumulative data, but they could provide the current year. Mr. Conley questioned whether the MGs could provide the most recent five book years inclusive of values for assumed and ceded. Ms. Javorek stated that five years would be possible and that moving forward, the cumulative would build. Mr. Meers concurred that they could also provide five years of data. Following additional discussion, five years of reporting would be required, with additional years added moving forward.

g. Question 5Aiii

Mr. Kohan said that the column for “Other Income” was migrated over and that the definition was unknown. Mr. Daleo said that it comes from the income statement and that it includes fee income, previously charged off recoverables and miscellaneous income. Mr. Conley said that the column would remain as it could be applicable and should be provided by book year.
h. **Question 5Aiv**

Mr. Conley commented that the title for column 17 would be changed to “Number of Claims Closed with Payment (Direct).” He also said that the title for column 26 would be changed to “Number of Delinquencies” and tied to schedule 2E, column 10, which defines the number of delinquencies as three or more consecutive missed payments. Nicholas Realmuto (National Mortgage Insurance Corporation) stated that changing both columns as suggested would more accurately reflect the data being collected.

i. **Question 5Av**

Mr. Conley stated that he concurs with changing all references from “Known Claims Reserves” to “Known Loss Reserves.”

j. **Question 5Avi**

Mr. Conley commented that there is uncertainty regarding the use of the term “bulk” and whether it should be included with primary flow or pool business. Mr. Realmuto commented that pool business could be subject to a deductible and treated in aggregate in terms of loss experience. He said that bulk is treated the same way as primary flow business in terms of individual policies and not on an aggregate basis in terms of losses. Mr. Conley commented that the SRMICS formula can be applied to primary flow and bulk business accurately. As a result, Mr. Conley concluded that primary flow would be added with bulk business.

k. **Question 5Bi**

Mr. Conley commented that 20 years of data would be required and that the Annual Statement Blank, Schedule P – Analysis of Loss and Loss Expenses should continue to be provided.

l. **Question 5Bii**

Mr. Conley stated that the prior year row should be reported back to 1993. Further, he indicated that all references to “accident year” will be replaced with “policy year.”

m. **Question 5Biii**

Mr. Conley commented that the paragraph would be removed.

n. **Question 5Biv**

Following a brief discussion, Mr. Conley said that the definition would be removed from the table.

o. **Question 6**

Mr. Daleo commented that there are four references that were requested to be reported in millions as a result of uncertainty of the length of the reported data. He indicated that “millions” could be removed since there is space for 15 characters. Mr. Conley concurred that the references to “millions” should be removed. Mr. Daleo commented that there are two references to interrogatories that also should be removed since there are no interrogatories with regard to the Exhibit. Mr. Conley concurred on removing the references.

The Working Group then briefly discussed a plan to: 1) summarize the amendments within a subsequent e-vote on the proposal; and 2) complete the balance of the agenda during a subsequent meeting.

Having no further business, the Mortgage Guaranty Insurance (E) Working Group adjourned.
Re: Proposed Mortgage Guaranty Insurance Exhibit and Instructions (the “MG Exhibit”).

Dear Mr. Daleo:

These comments on the MG Exhibit are submitted on behalf of the “MG Industry Group” consisting of Arch Mortgage Insurance Company, Essent Guaranty, Inc., Genworth Mortgage Insurance Corporation, Mortgage Guaranty Insurance Corporation, National Mortgage Insurance Corporation, and Radian Guaranty Inc. We appreciate your approval of a two week extension until April 1st to provide comments on the proposed MG Exhibit.

We have a few general questions and comments followed by some more technical issues:

1. We view the alterations to the scope of public disclosure associated with Schedule MG as extremely problematic from a confidentiality perspective. We point to Part 2C: Earned Premium triangle and Part 2D: SRMICS triangle as particularly problematic, as earned premium could be used to derive rate history and SRMICS could be used to derive change in risk quality for the book. As the MG Industry Group is comprised of public companies, we recommend that Schedule MG be implemented as a confidential filing under examination (or other similar) authority that the domestic regulators might share under terms of an MOU.

2. It is helpful to hear that the SRMICS triangle in this supplement continues to be tied to the Model Act. For now, we recommend against including the “Direct Calculated SRMICS” triangles (in Part 2D). It is uncertain whether the SRMICS model will be ready at the same time as this proposed Schedule MG, and the MG Industry Group considers it more appropriate to incorporate a request for provision of SRMICS data through Schedule MG if/when the SRMICS model is adopted.

3. We would like to understand if Schedule MG will be required of all companies, or on a voluntary basis depending on the domiciliary commissioner.

4. Is there a minimum company capital amount required for Schedule MG to be submitted? Some MG companies have smaller MG affiliates within their holding company systems and we request that Schedule MG only be applicable to flagship companies.
5. Technical Concerns

A. Schedule MG – Part 1.

i. Are Columns 1 (Original Risk In Force) and Column 2 (Current Risk In Force) direct or net? For additional clarity, is Column 1 as of December 31, 20xx? Meaning, for the 2012 policy year, new risk written as of December 31, 2012, could be different than new risk written throughout 2012 as a policy written in January could have been rescinded. For Column 2, the word “written” should be removed.

ii. Providing earned premium and paid losses (in Columns 3 to 17) cumulatively by policy year will be unduly onerous. All companies can provide direct (as also requested in the triangles for Part 2A and 2C) but some are unable to provide cumulative assumed/ceded/net (Columns 4, 6, 7, 9, 10, 12, 13, 16) due to the unavailability of past ceded and assumed information and changing internal reinsurance agreements in some companies’ histories. Accordingly, we recommend amending Columns 3 to 17 to request calendar year information.

iii. What is “Other Income” (Column 5)?

iv. The Summary requests the Number of Claims Reported (Direct) at Column 17 and Number of Claims Outstanding (Direct) at Column 26. We do not report this information for other NAIC schedules/supplements such as Schedule P. If we are expected to report this, we will require some additional definitions. For example, what is meant by the number of Claims Reported (Column 17)? Does it include current and paid claims? Does it include denied claims? Does it include NODs that have not filed claims? And, would Claims Outstanding (Column 26) include NODs or just filed claims? We note existing NAIC definitions would benefit from more clarification:

1. **Definition as per Schedule P – “The number of claims is to be cumulative by policy year. The number of claims reported for each policy year is equal to the number of open claims at the end of the current year plus cumulative claims closed with or without payment for the current and prior calendar years”** [Note that this doesn’t apply to Schedule P for monoline MG companies; however it applies for certain other industries.]

2. **Definition as per NAIC model laws (as applied to Health Insurance Contracts): “Claims reported” are considered as a reported claim for annual statement purposes when an insurer has been informed that a claim has been incurred, if the date reported is on or prior to the valuation date**

v. The header for Columns 18-20 should read “known loss reserves” or simply “loss reserves” rather than “claim reserves.” The current header implies the reserves for claims which would not make sense.
vi. For Part IA and IB, the MG Industry Group believes bulk should be combined with primary “flow” to be consistent with how the industry reports results.

B. Schedule MG, Part 2.

i. For Part 2 to 2E, are so many years necessary? Might we align with the years reported in Part 1 and Schedule P? Would this schedule replace the requirement for mortgage insurers to complete Schedule P?

ii. The Instructions for Part 2C state, “Only accident years 1993 and subsequent must be reported.” Does this refer to how far back the Prior row is expected to report? Also, we recommend references to accident year be changed to policy year.

iii. The Instructions state, “For report year development, group the claims by year in which the claim was first reported.” The year in which the claim was reported will be different than the policy year, so we seek clarification as to what we are being asked to report. Also, if we are reporting by the year the claim was reported, we believe this would be redundant with the results reported on Schedule P.

iv. Part 2E – Policy Year Direct Delinquencies. We recommend removing the definition of delinquencies from the header to the table. MG companies will define reporting to align with their reserve requirements. We request clarification as to whether the report seeks a snapshot of existing DQs (i.e. DQ inventory) or an “ever DQ” count, and recommend a calendar year inventory.

6. Housekeeping. Finally, we recommend conforming the tables, some of which are denoted in thousands while others are denoted in millions, and removing the reference to interrogatories on page 2 of the Instructions as there are no interrogatories associated with this Schedule MG.

We look forward to discussing these matters with the members of the Mortgage Guaranty Insurance Working Group at the April 6th meeting you have arranged, and are also prepared to engage on the comments previously submitted by the MG Industry Group with respect to the latest exposure draft of the Model Act and SRMICS.

Thank you for your consideration of our comments.

Respectfully submitted,

MG Industry Group
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

| CONTACT PERSON: | Andy Daleo |
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| ON BEHALF OF: | Mortgage Guaranty Ins. Working Group |
| NAME: | Kevin Conley |
| TITLE: | Chair |
| AFFILIATION: | NC Department of Insurance |
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FOR NAIC USE ONLY

- Agenda Item # __________
- Year 2021
- Changes to Existing Reporting [ X ]
- New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

- No Impact [ X ]
- Modifies Required Disclosure [ ]

DISPOSITION

- [ ] Rejected For Public Comment
- [ ] Referred To Another NAIC Group
- [ ] Received For Public Comment
- [ ] Adopted Date __________
- [ ] Rejected Date __________
- [ ] Deferred Date __________
- [ ] Other (Specify) __________

BLANK(S) TO WHICH PROPOSAL APPLIES

- [ X ] ANNUAL STATEMENT
- [ ] QUARTERLY STATEMENT
- [ X ] INSTRUCTIONS
- [ X ] BLANK
- [ ] Life, Accident & Health/Fraternal
- [ ] Separate Accounts
- [ ] Property/Casualty
- [ ] Protected Cell
- [ ] Health
- [ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2021

IDENTIFICATION OF ITEM(S) TO CHANGE

Add a new supplement Mortgage Guaranty insurance Exhibit to capture more information from mortgage guaranty insurers.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The proposed Mortgage Guaranty Insurance Supplement will be primarily used by the domestic regulators of mortgage guaranty insurers. Currently, there is limited data captured on mortgage guaranty insurance within the financial statement. The proposed supplement will provide the means for the regulators to assess the capital level of the insurer and their overall financial solvency.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: ____________________________

Other Comments: ____________________________________________

** This section must be completed on all forms.
ANNUAL STATEMENT INSTRUCTIONS - PROPERTY

MORTGAGE GUARANTY INSURANCE EXHIBIT

This exhibit is required to be filed no later than April 1.

All reporting entities reporting mortgage guarantees on Line 6 of the Annual Statement Underwriting and Investment Exhibit, Part 1 and/or Part 2 must prepare this Exhibit.

The following definitions should be used in completing the Mortgage Guaranty Insurance Exhibit:

a. “Primary Flow Business” means loans are insured on an individual loan-by-loan transaction basis. Premium rates typically vary depending on the perceived risk of a potential claim on the loan type based on consideration of the loan to value ratio, borrower credit score, payment plan, mortgage term and property type. The mortgage instrument may require the borrower to pay for the mortgage insurance, which is referred to as “borrower paid”. Alternatively, the lender may be required to pay the premium, who in turn recovers the premium through an increase in the note rate, which is referred to as “lender paid”.

b. “Pool and Bulk Business” means a collection of mortgages with similar rates and terms which are often securitized by dividing the pool into bonds backed by the payments of principal and interest into the pool by borrowers. Pool insurance typically covers the loss on a defaulted mortgage loan included in the pool, which is in excess of the loan’s primary coverage, as well as the total loss on a defaulted mortgage which does not require primary coverage. Pool insurance may have a stated aggregate loss limit for a pool of loans or a deductible under which no loss is paid by the insurer until the deductible is exceeded. Bulk Business means coverage is provided on each mortgage loan included in a defined portfolio of loans insured under a single or bulk transaction. Bulk coverage typically insures the closed loans in an insured portfolio to a specified level of coverage. Loans insured on a bulk basis are typically part of a negotiated transaction, resulting in a composite rate applied to all such loans in the portfolio.

SCHEDULE MG

There are five parts and the interrogatories within Schedule MG. Part 1 provides detailed information on losses and loss expenses. Part 2 provides a history of incurred losses and loss expenses on a policy year basis. If the reporting entity is unable to provide any part of the data required in Schedule MG for years prior to 1994, the company must obtain a letter of waiver from its domiciliary commissioner. A copy of this letter must be included with the reporting entity’s filing of the Mortgage Guaranty Insurance Exhibit. Data for 1994 and subsequent should be provided in complete detail except for adjusting & other expenses (A&O) that should be in complete detail for 1996 and subsequent.

Schedule MG includes only the data for the insurer identified on the cover of the exhibit. Do not include consolidated data for affiliated companies. If the insurer participates in a pooling agreement, it should report only its share of the business, not the total of all participants.

In those instances where an insurer files an amended annual statement as a result of a restatement of prior year written premium, losses or loss adjustment expenses, Schedule MG must be restated and included in the amended of the exhibit. In those instances where one insurer is merged into another mortgage guaranty insurer, Schedule MG must be prepared so it includes the entire combined history of both companies.

When changes to pooling agreements impact prior policy years, historical data values in Schedule MG Parts, 1 and 2 should be restated based on the new pooling percentage. This should be done to present meaningful development patterns in Schedule MG. When pooling changes only impact future policy years, no restatement of historical values should be made.

Earned premium is on a calendar-year basis. Losses incurred should be assigned to the year in which the policy was written that triggered coverage under the contract.

Retroactive reinsurance should not be reflected in Schedule MG. The transferor in such an agreement must record, without recognition of the retroactive reinsurance, its loss and loss adjustment expense reserves on a gross basis on its balance sheet and in all schedules and exhibits. The transferee in such an agreement must exclude the retroactive reinsurance from its loss and loss expense reserves and from its schedules and exhibits.
The reserves for unpaid losses and loss adjustment expenses should take into account the explicit or implicit impacts of the various factors affecting claim frequency or ultimate claim cost.
Schedule MG, Part 1 is organized so that written premiums and other income for a year are matched with corresponding losses and Defense & Cost Containment expenses (D&CC) and Adjusting & Other expenses for policies issued during that year. Experience is shown for direct business, reinsurance assumed, reinsurance ceded and net of reinsurance.

Policy year loss and loss adjustment expense payments and reserves should be assigned to the year in which the policy was written under which coverage is triggered.

Part 2 displays 20-year loss development triangles on a policy year basis. In Part 2, losses are combined with D&CC. Loss and D&CC development is shown for total incurred, payments, case basis reserves, bulk reserves and incurred but not reported (IBNR) reserves (policy year basis only). Part 2 displays 20-year claim count development triangles on a policy year basis.

For report year development, group the claims by year in which the claim was first reported. The reserves reported are expected to represent the ultimate amounts to be paid, including anticipated inflation.

Report all dollar amounts in Schedule MG in thousands of dollars ($000 omitted), either by rounding or truncating. All claim counts are to be shown in whole numbers.

The number of claims reported is to be cumulative by policy year. The number of claims reported for each policy year is equal to the number of open claims at the end of the current year plus cumulative claims closed with or without payment for the current and prior calendar years.

For reporting entities reporting on a pooling basis, the pooling percentage should be applied to claim count as well as dollar amounts.

If the company changes its method of counting claims, the new method should be disclosed in the Notes to Financial Statements.
SCHEDULE MG - PART 1 – SUMMARY

Part 1 – Summary provides a 10-year summary of loss and defense & cost containment experience for the company. Part 1 – Summary should be equal to the sum of Part 1A and Part 1B. Columnar headings provide instructions necessary for completion.

The columnar headings provide instructions necessary for completion.

For each year, Number of Claims Reported (Column 17) should include the cumulative number of claims reported through the annual statement date for pooled and non-pooled business. For reporting entities reporting on a pooling basis, the pooling percentage should be applied to claim count as well as dollar amounts. Indicate in the Interrogatories whether per claim or per claimant.

Cumulative salvage and subrogation received and losses and expenses paid should be reported for each specific year. For “prior,” report only salvage and subrogation received and losses and expenses paid in current year.

In Schedule MG, Part 1, salvage and subrogation received should be reported net of reinsurance, if any. Loss payments are to be reported net of salvage and subrogation received in Schedule MG.

Adjusting & Other Payments, Column 15, should reflect net payments in 1996 and prior and direct and assumed payments for 1997 and subsequent.

Premiums earned and losses paid, unpaid, and incurred should reconcile with the Statement of Income page. The workpapers that show a reconciliation explaining reinsurance and salvage and subrogation adjustments should be available for examination on request.

“Assumed” means reinsurance assumed, including from affiliated pooling agreements, but excluding any non-proportional reinsurance assumed reported as a separate line and reported accordingly.

“Direct” means as directly written, but not if part of an affiliated pooling agreement.

“Ceded” means reinsurance ceded on business so reported as direct or assumed.

Line 1, “Prior,” Columns 8 through 16 should only reflect amounts paid or received in the current calendar year.

Report cumulative amounts paid or received for specific years.

“Defense & Cost Containment” expenses include defense, litigation and cost containment expenses, whether internal or external. “Defense” means defense by the reporting entity in a contentious situation, whether a first party or a third-party claim. The fees charged for reporting entity employees should include overhead, just as an outside firm’s charges would include. The expenses exclude expenses incurred in the determination of coverage. These expenses include the following items:

1. Surveillance expenses;
2. Fixed amounts for cost containment expenses;
3. Litigation management expenses;
4. Loss adjustment expenses for participation in voluntary and involuntary market pools if reported by accident year;
5. Fees or salaries for appraisers, private investigators, hearing representatives, inspectors and fraud investigators, if working in defense of a claim, and fees or salaries for rehabilitation nurses, if such cost is not included in losses;
6. Attorney fees incurred owing to a duty to defend, even when other coverage does not exist; and
7. The cost of engaging experts.
“Adjusting & Other” expenses are those expenses other than those above and which have been assigned to the “Loss Adjustment Expense” group in the Underwriting and Investment Exhibit, Part 3, Expenses. These expenses include the following items:

1. Fees of adjusters and settling agents (but not if engaged in a contentious defense);
2. Loss adjustment expenses for participation in voluntary and involuntary market pools if reported by calendar year;
3. Attorney fees incurred in the determination of coverage, including litigation between the reporting entity and the policyholder; and
4. Fees or salaries for appraisers, private investigators, hearing representatives, re-inspectors and fraud investigators, if working in the capacity of an adjuster.

The foregoing list is not intended to be all-inclusive. We are relying on the reporting entities to use reasonable judgment in particular situations.

Reporting entities should assign the “Defense & Cost Containment” expenses to the policy year in which the associated losses were assigned. Reporting entities may assign the “Adjusting & Other” expenses in any justifiable way among the policy years. The preferred way is to apportion these expenses in proportion to the number of claims reported, closed, or outstanding each year.

Please Note: This instruction is intended solely to give guidance on reporting loss adjustment expenses in Schedule MG in the annual statement. It is not intended to provide guidance on the types of expenses to include in loss adjustment expenses. These definitions of defense & cost containment expense and adjusting & other expense are not intended to affect insurance or reinsurance agreements or other contractual agreements.

Pooling

Many insurers have a pooling arrangement with affiliated companies, approved by the domiciliary commissioner, in which the business written is reallocated among the affiliated companies according to a specified percentage. Some affiliated companies may be part of the pool and some may not, and some lines may be included, and some may not. The premiums and losses are to be reported in Schedule P after such pooling arrangements, not before.

Pooled business ceded is that which, if retained instead of ceded, would be pooled among the affiliated companies who are party to the pooling agreement. Any such business that is ceded by the pool participants to non-pooled companies prior to the pooling distribution among the participating companies is considered pooled business ceded. Non-pooled business includes all direct, assumed, and ceded business not subject to pooling, as well as any pooled business that is ceded after the pooling distribution has been made.

Direct and Assumed columns include the participation in any pool. In addition, all direct business not pooled plus assumed business from other than the pool is to be included. Ceded columns include the company’s participation in the pool such as any ceding by the company to companies independent of the pool.

Claim counts should be reported in accordance with the pooling arrangement and should reflect the company’s proportionate share of the total number of claims. If the company’s losses are 40% of the pool, then 40% of the claim count should be reported.

The pooling percentage is to reflect the company’s participation in the pool as of year-end. When changes to pooling agreements impact prior policy years, historical data values in Schedule MG Parts, 1 and 2 should be restated based on the new pooling percentage. This should be done to present meaningful development patterns in Schedule MG. When pooling changes only impact future policy years, no restatement of historical values should be made.
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<td>Premiums Earned and Other Income Net</td>
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<td>Total Net Loss and Expense Paid</td>
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<td>Total Net Loss and LAE Unpaid</td>
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<td>27</td>
<td>Losses and Defense &amp; Cost Containment Expenses Incurred Direct</td>
<td>$8 + 11 + 18 + 21$</td>
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<tr>
<td>28</td>
<td>Losses and Defense &amp; Cost Containment Expenses Incurred Assumed</td>
<td>$9 + 12 + 19 + 22$</td>
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<tr>
<td>29</td>
<td>Losses and Defense &amp; Cost Containment Expenses Incurred Ceded</td>
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<td>Loss and LAE Ratio Direct Basis</td>
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<td>32</td>
<td>Loss and LAE Ratio Net Basis</td>
<td>$(15 + 24 + 30)/(7 - 5)$</td>
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<td>33</td>
<td>Net Loss &amp; LAE Coverage</td>
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<td>34</td>
<td>Net Reserves</td>
<td>$25 - 33$</td>
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SCHEDULE MG – PARTS, 1A and 1B

Reporting entities should complete Schedule MG in thousands only but must report all claim counts in whole numbers.

NOTE: For “prior,” report amounts paid or received in current year only. Report cumulative amounts paid or received for specific years. Report loss payments net of salvage and subrogation received.

The number of claims reported is to be cumulative by accident year. The number of claims reported in each accident year is equal to the number of open claims at the end of the current year plus cumulative claims closed with or without payment for current and prior calendar years.

Column 7 – Premiums Earned and Other Income Net

Should equal Columns 3 + 4 + 5 – 6.

Column 16 – Total Net Loss and Expense Paid

Should equal Columns 8 + 9 – 10 + 11 + 12 – 13 + 15.

Column 25 – Total Net Loss and LAE Unpaid


Column 27 – Losses and Defense & Cost Containment Expenses Incurred Direct

Should equal Columns 8 + 11 + 18 + 21.

Column 28 – Losses and Defense & Cost Containment Expenses Incurred Assumed

Should equal Columns 9 + 12 + 19 + 22.

Column 29 – Losses and Defense & Cost Containment Expenses Incurred Ceded

Should equal Columns 10 + 13 + 20 + 23.

Column 30 – Losses and Defense & Cost Containment Expenses Incurred Net

Should equal Columns 27 + 28 – 29.

Column 31 – Loss and LAE Ratio Direct Basis

Should equal (Columns 15 + 24 + 27)/Column 3.

Column 32 – Loss and LAE Ratio Net Basis

Should equal (Columns 15 + 24 + 30)/(Columns 7 – 5).

Column 33 – Net Loss & LAE Coverage

Should equal (Columns 15 + 24 + 30)/Column 1.

Column 34 – Net Reserves

Should equal Columns 25 – 33.
SCHEDULE MG- PART 1A – PRIMARY FLOW BUSINESS

Part 1A provides a summary of primary flow business premium, payments, claims, and reserves by policy year. Columnar headings provide instructions necessary for completion.

SCHEDULE MG- PART 1B – POOL AND BULK BUSINESS

Part 1B provides a summary of pool and bulk flow business premium, payments, claims, and reserves by policy year. Columnar headings provide instructions necessary for completion.

SCHEDULE MG- PART 2
POLICY YEAR DIRECT INCURRED LOSS AND DEFENSE & COST CONTAINMENT EXPENSE

Part 2 provides a historical summary of loss and defense & cost containment expenses development by policy year. Columnar headings provide instructions necessary for completion.

The definition of “prior years” should be the same as that used by the company in Part 1.

SCHEDULE MG- PART 2A
POLICY YEAR DIRECT PAID LOSS AND DEFENSE & COST CONTAINMENT EXPENSE

Part 2A shows cumulative direct loss and defense & cost containment expense payments by year the policy was written as of December 31 of each year shown in Columns 1 to 10.

SCHEDULE MG- PART 2B
POLICY YEAR DIRECT CURRENT RISK IN FORCE

Part 2B provides a policy year summary of direct risk in force.

SCHEDULE MG- PART 2C
POLICY YEAR DIRECT EARNED PREMIUM

For Schedule MG, Part 2C, the premiums to be reported are exposure or coverage year earned premiums, recalculated each subsequent year to reflect audits, retrospective adjustments based on loss experience, accounting lags, etc. Mechanically, the earned premium file would be restated and the earned premium calculation repeated each year. Premium adjustments for policy periods that cover more than one calendar year should be proportionately distributed between the calendar years covered by the policy period. The objective is to develop earned premiums by calendar year of coverage consistent with the loss and Defense & Cost Containment expense by policy year. Only accident years 1993 and subsequent must be reported.
Part 2D provides a policy year summary of direct calculated State Regulatory Mortgage Insurance Capital Standard (SRMIC).

Part 2E provides a policy year summary of direct delinquencies.
ANNUAL STATEMENT BLANK - PROPERTY

MORTGAGE GUARANTY INSURANCE EXHIBIT

FOR THE YEAR ENDED DECEMBER 31, 20XX

(To Be Filed by April 1)

Of: ………………………………………………………………………

Attachment Four-B
Financial Condition (E) Committee
4/13/21

© 2021 National Association of Insurance Commissioners
## SCHEDULE MG- PART 1 – SUMMARY

### (S000 OMITTED)

<table>
<thead>
<tr>
<th>Years in Which Policies Written</th>
<th>Original Risk In Force Written in Millions</th>
<th>Current Risk In Force Written in Millions</th>
<th>Premium Earned and Other Income</th>
<th>Loss and Defense &amp; Cost Containment Expenses Payments</th>
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<tr>
<th>Loss and Defense &amp; Cost Containment Expenses Unpaid</th>
<th>Adjusting &amp; Other Expense Payments</th>
<th>Salvage and Subrogation Recovered</th>
<th>Total Net Loss and Expense Paid</th>
<th>Number of Claims Reported (Direct)</th>
<th>Known Claim Reserves</th>
<th>IBNR Reserves</th>
<th>Adjusting &amp; Other Expense Unpaid</th>
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<tr>
<th>Total Net Loss and LAE Unpaid</th>
<th>Number of Claims Outstanding (Direct)</th>
<th>Losses and Defense &amp; Cost Containment Expenses Incurred</th>
<th>Loss and LAE Ratio</th>
<th>Net Loss &amp; LAE Coverage</th>
<th>Net Reserve</th>
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## SCHEDULE MG- PART 1A – PRIMARY FLOW BUSINESS

### Premiums Earned and Other Income

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<tr>
<th>Years in Which Policies Written</th>
<th>Premiums Earned and Other Income</th>
<th>Loss and Defense &amp; Cost Containment Expenses Payments</th>
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### Losses and Defense & Cost Containment Expenses Unpaid

<table>
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<th>Years in Which Policies Written</th>
<th>Losses and Defense &amp; Cost Containment Expenses Unpaid</th>
<th>Loss and LAE Ratio</th>
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### SCHEDULE MG - PART 1B - POOL AND BULK BUSINESS

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### SCHEDULE MG- PART 2 – POLICY YEAR DIRECT INCURRED LOSS AND DEFENSE & COST CONTAINMENT EXPENSE

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*State Regulatory Mortgage Insurance Capital Standard

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The National Treatment and Coordination (E) Working Group of the Financial Condition (E) Committee met March 4, 2021. The following Working Group members participated: Debbie Doggett, Co-Chair (MO); Linda Johnson, Co-Chair (WY); Cindy Hathaway (CO); Joan Nakano and William Mitchell (CT); Alisa Pritchard (DE); Virginia Christy (FL); Stewart Guerin (LA); Kari Leonard (MT); Cameron Piatt (OH); Greg Lathrop (OR); Cressinda Bybee (PA); Robert Rudnai (TX); Jay Sueoka (UT); Susan Baker and Ron Pastuch (WA); and Amy Malm (WI).

1. **Adopted its Revised 2021 Charges**

   The Working Group adopted its revised 2021 charges to absorb the charges from the Biographical Third-Party Review (E) Subgroup and disband the Subgroup. Ms. Doggett said the Biographical Third-Party Review (E) Subgroup was established in 2011 when the Working Group determined there was a need to establish uniformity in the background investigation reports prepared by a third-party. She added that since August 2017, the Subgroup has been chaired by Cameron Piatt (OH), and with the development of a biographical database in the near future, the current work of the Subgroup has been completed. She thanked Mr. Piatt for his diligent work on this Subgroup. She also thanked the Subgroup members: Amy Stuart (IL), Jay Sueoka (UT) and Ron Pastuch (WA), as well as Kathy Kelley (NV) and Joel Sander (OK), who have both since retired.

   Ms. Malm made a motion, seconded by Mr. Lathrop, to adopt the revised 2021 charges (Attachment Five-A) and disband the Biographical Third-Party Review (E) Subgroup. The motion passed unanimously.

2. **Discussed a Change of Control Referral**

   Ms. Doggett said that an ad hoc group from the Chief Financial Regulators submitted this referral to the Working Group. Ms. Bybee said that Pennsylvania was recently aware that the Form A database allows for the notice of closing to be recorded. She said she is curious if other states were using that status and if providing the details of the closing as part of their procedures and would solve the issue raised. Ms. Doggett said that using the closed date would remove the filing from the list of open files for each state but would not trigger any other action within the NAIC database for the company demographics to update the group code for the target entity or to the acquiring party that corporate amendment filings must be submitted to the foreign states. Ms. Bybee said that Pennsylvania has developed an internal process to make sure that its records are updated and that information is sent to the NAIC to update the group code. Companies are not consistent in regard to contacting the NAIC to have the group code, CoCode or company name updated after the transaction is closed. Jane Barr (NAIC) reminded the states that the Form A database does have a specific tab that pertains to updated information after the transaction has closed that allows the state to provide the updated group code, CoCode and company name. She did add that it does not send an automatic email notification to the NAIC but can consider this an enhancement if the states choose to use the post-acquisition page. There are procedures established in the *Company Licensing Best Practices Handbook* that detail the steps regarding post acquisitions.

   Ms. Doggett said that the Working Group will continue discussion of this referral during future meetings to determine the best solution on where instructions or enhancements should be added to current processes.

3. **Exposed Proposal 2021-01**

   Ms. Johnson said the purpose of the revised primary application is to separate initial start-up companies and companies that are redomesticating. Since its inception, the primary application and instructions were developed to include start-ups and redomestication applications filed with a domiciliary state in hard copy. The primary application and instructions have been revised and refined for start-up companies only. She said that two new forms have been created to capture management information (Form 4P) and holding company debt to equity information (Form 5P). With the implementation of the electronic application, state-specific requirements will be captured, as well as electronic signatures. The anticipated production date for the primary electronic application is 2022. She said that Form 2P will include surplus lines insurer designations for those states that have enacted the domestic surplus lines legislation.

   Ms. Johnson said the Primary Ad Hoc group has recommended exposing the proposal for a 45-day public comment period ending April 19.
4. **Exposed Proposal 2021-02**

Ms. Johnson said the redomestication application (Proposal 2021-02) is intended for companies that are redomesticating from one state to another. The original primary application was revised to remove all requirements for start-up companies, and the electronic format will capture state-specific requirements. The redomestication forms will be labeled as 1R, 2R and so on. The production release is anticipated in late 2022.

Ms. Johnson said that the Primary Ad Hoc group also recommended exposing the proposal for a 45-day public comment period ending April 19. She added that once the comments are received and the proposals are adopted, an effective date will be determined on when the forms will be posted to the Uniform Certificate of Authority Application (UCAA) website for use.

5. **Received a Status Update on the Electronic Application Ad Hoc Group**

Ms. Barr said that the ad hoc group began meeting in August 2020 to gather business rules for the primary (start-up) application and then the redomestication application. She said the ad hoc group is currently discussing business rules for domestic corporate amendment applications. From there, it will begin working on an electronic Form A application and create forms based on the *Insurance Holding Company System Regulatory Act* (#440). The intent of the electronic Form A application will be to prepopulate pertinent information into the Form A database. She added that future enhancements will include Form B, C, D and E of Model #440 and asked if anyone was interested in joining the ad hoc group to contact her directly. The ad hoc group meets every two weeks to review mock-up forms and discuss state requirements. Ms. Barr said that once all the electronic applications have been developed and current applications enhanced, the ad hoc group will begin developing the biographical affidavit database. She added that a specific timeline has not been laid out because the developers are finishing a current project, which has caused some delays.

Ms. Johnson asked if the Form A database ad hoc group could look into some items from the change of control referral to enhance the processes. Ms. Barr concurred and asked if the Working Group, through its discussion, could provide some objectives for the ad hoc group to consider incorporating into the electronic format or how it could trigger some automated notifications for state insurance regulators, the NAIC and the applicant company.

6. **Received an Update on the Domestic Surplus Lines Ad Hoc Group**

Crystal Brown (NAIC) said that the ad hoc group was formed last year based on a referral the Working Group received from the Chief Regulator Forum regarding domestic surplus lines carriers and whether they have enacted the new legislation. A survey was sent to the states to determine which states had enacted the legislation and found that 19 states of the 41 states that responded adopted the domestic surplus lines legislation. Ms. Brown said the ad hoc group will review the state statutes and regulations from the 19 states to identify similarities that can be incorporated into guidance or used to clarify the annual statement instructions or code list for the reporting of these types of carriers on Schedule T.

7. **Discussed Other Matters**

   a. **Forms 2 and 14**

Ms. Barr said that a couple of states have reached out to the NAIC staff regarding an enhancement to the current Form 2 and Form 12 to capture the applicant company’s web address. When there is a change of control, there may be a gap when the company is providing its financial reports to the NAIC, so the NAIC database may not have the most current company information.

Another request to Form 2 was to include: 1) the first and last name of the contacts currently listed on Form 2; 2) premium tax, producer licensing, and rate and form filing contacts; and 3) the company compliance contact. Ms. Barr said that these suggestions were not included in the items to be exposed to avoid confusion with the current proposals being exposed that include Form 2P and Form 2R, but they could be included for consideration during the Working Group’s next meeting. Ms. Doggett said that the changes are not significant and agreed that the Working Group could consider them during its next meeting. Ms. Barr said that there could be a delay when these changes could be implemented into the electronic applications.

   b. **Company Licensing Collaboration Page**
The National Treatment and Coordination (E) Working Group will:

A. Increase utilization and implementation of the *Company Licensing Best Practices Handbook*.
B. Encourage synergies between corporate changes/amendments and rate and form filing review and approval to improve efficiency.
C. Continue to monitor the usage and make enhancements to the Form A Database.
D. Maintain educational courses in the existing NAIC Insurance Regulator Professional Designation Program for company licensing regulators.
E. Make necessary enhancements to promote electronic submission of all company licensing applications.
F. Monitor the ongoing adherence of background investigation reports and third-party vendors and increase uniformity of state requirements regarding concerns or changes to key individuals’ fitness and propriety.

H. The Biographical Third-Party Review (E) Subgroup of the National Treatment and Coordination (E) Working Group will:

   a. Increase the uniformity of the third-party vendors that prepare background investigative reports to those state insurance departments that require them. Reduce the inefficiency of applications by developing procedures and approval processes.
   b. Monitor the ongoing adherence of background investigation reports and third-party vendors.
   c. Encourage uniformity of requirements in relation to individuals’ fitness and propriety and the company's responsibility in notifying state insurance departments of concerns or changes to key individuals.
PROJECT HISTORY

GUIDELINE FOR DEFINITION OF RECIPROCAL STATE IN RECEIVERSHIP LAWS

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

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

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

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

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

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

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

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

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

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

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

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

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

The Guideline was drafted by Task Force members: Florida; Maine; Texas; and Patrick Cantilo (Cantilo and Bennett LLP), an interested party. This drafting group met Oct. 19, 2020, and considered language contained in both the Florida and Maine laws.
Rather than identifying a list of specific key provisions in law that would be required for a state to be defined as “reciprocal,” the drafting group agreed to use the same criteria used by the NAIC Financial Regulation Standards and Accreditation Program. Under this definition, any state meeting the applicable NAIC Part A accreditation standards for receivership laws, which requires a state to have a “receivership scheme,” will be treated as a reciprocal state. The definition recognizes the diversity of existing state receivership laws, and it should avoid unnecessary litigation regarding the recognition of a state as a reciprocal state.

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

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

The Task Force did not receive any comments.

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

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

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

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

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

“Reciprocal state” means a state that has enacted a law that sets forth a scheme for the administration of an insurer in receivership by the state’s insurance commissioner [or substitute the equivalent title used by the state, such as superintendent or director] or comparable insurance regulatory official.

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

The Guideline will not be considered for any accreditation standard.
Draft 3/12/21
Adopted by the Executive (EX) Committee and Plenary.
Adopted by the Financial Condition (E) Committee April 13, 2021
Adopted by the Receivership and Insolvency (E) Task Force March 12, 2021

GUIDELINE FOR DEFINITION OF RECIPROCAL STATE IN RECEIVERSHIP LAWS

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

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

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

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

Definition of Reciprocal State for Receivership

“Reciprocal state” means a state that has enacted a law that sets forth a scheme for the administration of an insurer in receivership by the state’s insurance commissioner [or substitute the equivalent title used by the state, such as superintendent or director] or comparable insurance regulatory official.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)
[insert reference if adopted]
2021 Proposed Amended Charges

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

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

3. The Receivership Law (E) Working Group will:
   A. Review and provide recommendations on any issues identified that may affect states’ receivership and guaranty association laws (e.g., any issues that arise as a result of market conditions; insurer insolvencies; federal rulemaking and studies; international resolution initiatives; or as a result of the work performed by or referred from other NAIC committees, task forces and/or working groups).
   B. Discuss significant cases that may impact the administration of receiverships.
   C. Complete work as assigned from the Receivership and Insolvency (E) Task Force to address recommendations from the Financial Stability (EX) Task Force’s Macroprudential Initiative (MPI) referral:
      1. Complete work related to qualified financial contracts (QFCs), including: 1) explore if bridge institutions could be implemented under regulatory oversight pre-receivership to address an early termination of QFCs and, if appropriate, develop applicable guidance; 2) develop enhancements to the Receiver's Handbook guidance on QFCs; and 3) identify related pre-receivership considerations related to QFCs and, if necessary, make referrals to other relevant groups to enhance pre-receivership planning, examination and analysis guidance.
      2. Review and provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities. Among other solutions, this will
encompass a review of the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to provide proposed revisions to address the continuation of essential services through affiliated intercompany agreements in a receivership.

3. Consult with and/or make referrals to other NAIC working groups, as deemed necessary, as the topic relates to affiliated intercompany agreements and pre-receivership considerations. Complete by the 2021 Fall National Meeting.

4. The **Receiver’s Handbook (E) Subgroup** will:
   A. Review the Receiver's Handbook to identify areas where information is outdated, updates are required, or additional guidance is needed. Based on this review, draft and propose recommended edits to the Receiver’s Handbook.
   B. Complete by the 2022 Fall National Meeting.

NAIC Support Staff: Jane Koenigsman/Sherry Flippo
MEMORANDUM

To: Financial Condition (E) Committee
From: Jamie Walker, Accounting Practices and Procedures (E) Task Force
Date: March 31, 2021
Re: Agenda item 2019-24: Levelized and Persistency Commission

This memorandum is to provide an overview of the key points of the levelized commission agenda item 2019-24, which affects SSAP No. 71—Policy Acquisition Costs and Commissions. The Statutory Accounting Principles (E) Working Group began discussion in August 2019 and on March 15, 2021, adopted revisions (see illustrated revisions page 5) which are effective Dec. 31, 2021. The Working Group vote was 13 states in favor and one state opposed. On March 23, 2021, the Accounting Practices and Procedures (E) Task Force adopted the revisions as adopted by the Working Group with a vote of 41 members in favor and two opposed (LA and OK).

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

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

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

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

Disputed practice: Those few insurers that are not recognizing the full liability under the funding agreement (to repay the parties who are paying acquisition costs on their behalf) are not following the long-standing guidance in SSAP No. 71. These limited companies are only recognizing a fraction of the acquisition commission expense, which results in misleading financial statements, and presents a better financial position than actually exists (as the company has unrecorded liabilities for commissions already paid on their behalf). SSAP No. 71 requires recognition of the full liability amount of such an agreement, even if repayment is not guaranteed. The small number of insurers have asserted that their reporting is a decades-long practice. However the SSAP No. 71 guidance that requires full accrual of the liability was adopted in 1998 and is based on even earlier statutory accounting guidance which notes that, “The accounting treatment for certain transactions, characterized as levelized commissions, which results in enhancement of surplus, has been determined to be inappropriate for statutory reporting.” The Working Group discussions identified that not recognizing the full liability appears to have been practiced by only a small minority of companies, which supports that the majority of industry is reporting correctly.

• Lapse - Lapse risk is a risk identified in Model 791 Life and Health Reinsurance, as a significant insurance risk therefore it cannot be transferred to a non-insurance entity. However, some employing the disputed practice have tried to assert that it has been transferred to the funding agent.

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

• Substantive / Nonsubstantive - The determination of a change as substantive or nonsubstantive is based on whether the edits reflect original intent (nonsubstantive) or incorporates new accounting concepts (substantive). Throughout the discussion process, it has been reiterated that the edits simply clarify the original intent of SSAP No. 71. As such, the change was classified as nonsubstantive. The impact to companies or the number of companies that have incorrectly applied accounting guidance is not a factor in determining whether a clarifying edit is substantive or nonsubstantive. However, the incorrect application only seems to involve a limited number of linked-companies, with other entities following the original intent of SSAP No. 71, which supports that the changes are nonsubstantive and
consistent with original intent. The March 15 Working Group discussion affirmed the nonsubstantive classification of the revisions was consistent with the policy statement.

- **Correction of Error / Change in Accounting Principle:** An earlier comment from an impacted company identified that there is a process concern as the edits to SSAP No. 71 are classified as a change in accounting principle and not a correction of error. *(Under SSAP No. 3—Accounting Changes and Correction of Errors, a mistake in the application of accounting principles is a correction of an error.)* The edits proposed in July 2020 were to classify changes required from misapplication of SSAP No. 71 as a correction of error. However, in response to comments, the Working Group agreed to designate the impact as a change in accounting principle. This provision was provided to assist companies in reflecting the change. Both processes require the impact to be recognized to unassigned funds (surplus). If reported as a correction of an error, then an entity may be subject to filing amended financial statements for periods in which the error was reflected. As a change in accounting principle, then the entity calculates the change as a cumulative effect to the Jan. 1 balance in the current year financials.

- **Use of Funding Agreements:** SSAP No. 71 does not prohibit the use of funding agreements or the use of third parties to pay commission expense to selling agents. SSAP No. 71 simply requires consistent recognition of commission expense based on policy issuance or renewal. The involvement of third parties and funding agreements to front commission owed to selling agents is not a free service. These third-parties require fees and interest from these financing arrangements; which presumably exceeds the costs of commission only. The long-standing guidance in SSAP No. 71 requires recognition of the full amount of unpaid principal and interest accrued to date in these arrangements. One comment raised during the discussion was that the clarified guidance would hurt policyholders. This comment was never fully substantiated, but it was noted that failing to report expenses in line with SSAP No. 71 would result with inappropriate financial positions – which could hurt policyholders. Additionally, it was noted that if the process to defer expense recognition was sanctioned, then all insurers would have to engage in these arrangements to prevent competitive disadvantages with reporting.

- **Payments to the Direct Agent:** Some of the comments received from the impacted companies (or their representatives) have tried to indicate that the timing (and how) the initial sales commission is paid to the direct selling agent by the third-party should not impact the recognition of commission expense by the insurer. These comments were made because it has been highlighted that in the known situations, the third-party agents have already paid the direct selling agent the owed commission. Although the third-party payment to the direct selling agent substantiates that a commission was owed from policy issuance, the payment to the direct agent is not the triggering event. *(Meaning, even if a third-party was to revise their agreements with direct agents to delay payment, this will not change that the insurer owes commission expense from policy issuance.)*

- **Consistent Application Across Companies:** SSAP No. 71 is a “common area” SSAP and applies to all entities regardless of their line of business or product offerings. Some comments made to regulators have implied that certain large companies are permitted processes that are not in line with SSAP No. 71. It is speculated that these comments are trying to compare commission expenses from renewals (which are not required until policy renewal occurs) to the process engaged by these companies in which they have not recognized commission expense from the initial issuance of policies. This goes back to these impacted companies mischaracterizing these financing arrangements as “persistency” commission. These timing arrangements do not alter the requirement to recognize commission expense with the issuance of a policy. Because many of these funding agreements were mischaracterized, it was noted that the disputed practice is difficult to identify on financial examinations and audits. One Working Group member shared that they had dealt with an issue like this previously when $16 million of off-balance sheet commission liabilities was identified after a third party funding agent applied to the liquidator for reimbursement.

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

• Effective Date: Although nonsubstantive revisions are generally effective upon adoption, the Working Group ultimately determined to have a Dec. 31, 2021 effective date. Two of the industry commenters (Guggenheim and interested parties (Delaware Life)) stated support for an effective date no sooner than Dec. 31, 2021 at the March meeting. Annual 2020 effective dates were previously deferred. While some members of the Working Group supported an effective date earlier in 2021, it was discussed that a year-end 2021 effective date would allow insurers, to assess the impact and review contracts, and additionally allow the issue to be fully through the NAIC committee process. During the March meeting, the National Council of Insurance Legislators (NCOIL) comments were supportive of a later effective date or an extended phase-in period. The Working Group determined that a year-end 2021 effective date was preferred because of the competitive issues and because the revisions were viewed as a clarification of long-standing guidance. The Working Group also reiterated its prior comments that the limited number of companies seeking phase in application could seek a permitted practice and that the permitted practices disclosures would provide regulatory transparency.
Adopted Revisions to SSAP No. 71 (new text from the prior exposure is shown as shaded):

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

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

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

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

**Effective Date and Transition**

7. This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with SSAP No. 3—*Accounting Changes and Corrections of Errors*. The nonsubstantive revisions adopted March 15, 2021 regarding levelized commission are to clarify the original intent of this statement and apply to existing contracts in effect as of December 31, 2021 and new contracts thereafter.
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Blanks (E) Working Group Agenda Item Submission Form 2020-30BWG Modified; Effective Annual 2021; Move the Interrogatory Question Regarding Communication of Internal Control Related Matters Noted in Audit from the Annual Supplemental Exhibits and Schedules Interrogatories to the Quarterly Supplemental Exhibits and Schedules Interrogatories to be Answered for the Second Quarter (Attachment Two-A3).................................................................................................................. 10-301
Blanks (E) Working Group Agenda Item Submission Form 2020-31BWG; Effective Annual 2021; Replaces the Life and Health Insurance Guaranty Association Model Act (#520) Assessment Base Reconciliation and the Adjustments to the Model #520 Assessment Base Reconciliation Exhibits with Modernized Exhibits in Order to Promote Consistent Reporting of Assessable Premiums Among Industry Members and Reflect Changes in Guaranty Association Laws Adopted Over the Past Two Decades (Attachment Two-A4)................................................................. 10-309
Blanks (E) Working Group Agenda Item Submission Form 2020-32BWG; Effective Annual 2021; Add New Health Care Receivables Supplement to the Life/Fraterna Annual Statement that Adds Exhibits 3 and 3A from the Health Annual Statement to the Life/Fraternity Annual Filings; Add Guidance Document Reference to Exhibit 3A of the Health Annual Statement (Attachment Two-B).................................................................................................................. 10-345
Blanks (E) Working Group Agenda Item Submission Form 2020-33BWG Modified; Effective First Quarter 2022; Modify Annual Statement Lines (ASLs) Used on Underwriting and Investment (U&I) Exhibits, State Page and Insurance Expense Exhibit (IEE); Change Health ASL Categories Used in Property to be Consistent with Other Statement Types; Update ASL References Used in Crosschecks; Update Definitions Used in the Appendix for the Health ASLs (Attachment Two-C).................................................................................................................. 10-351
Blanks (E) Working Group Agenda Item Submission Form 2020-34BWG; Effective Annual 2021; Add Definitions for the Occupational Accident, Fiduciary Liability Premises and Operations (OL&T and M&C), Professional Errors and Omissions Liability, Kidnap & Ransom Liability and Tuition Reimbursement Plans Products to the Appropriate Line of Business in the Appendix (Attachment Two-D).................................................................................................................. 10-367
Blanks (E) Working Group Agenda Item Submission Form 2020-35BWG Modified; Effective First Quarter 2022; Expand the Number of Characters Used from Seven to 10 in the Investment Line Categories for Schedules D, DA, DL and E Excluding Schedule D, Part 6 (Sections 1 and 2) and Schedule E (Part 1 and 3); Add Line Categories for Unaffiliated Certificates of Deposit (CDs) and Exchange Traded Funds (ETFs); Split the Line Categories for Mutual Funds, Investment Unit Trusts and Closed-End Funds into Lines Indicating if the Fund has been Assigned a Designation by the Securities Valuation Office (SVO); Make Changes to Summary Investment Schedule, Summary by Country and Schedule D, Part 1A (Sections 1 and 2) to Reflect the Additional Line Categories (Attachment Two-E).................................................................................................................. 10-375
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Blanks (E) Working Group Agenda Item Submission Form 2020-37BWG; Effective Annual 2021; Add New Schedule Y, Part 3, to Capture all Entities with Ownership Greater than 10%, the Ultimate Controlling Parties of Those Owners and Other Entities that the Ultimate Controlling Party Controls (Attachment Two-G).................................................................................................................. 10-462
Blanks (E) Working Group Agenda Item Submission Form 2020-38BWG Modified; Effective Annual 2021 (Except State Level Detailed Which Will be Effective Annual 2022); Make Changes to the Accident and Health Policy Experience Exhibit by Adding New Columns, Removing Lines Distinguishing with and without Contract Reserves; Add New Product Lines; Eliminate Summary Tables; Change the Date that the Exhibit is Due and have it Reported by State (Attachment Two-H).................................................................................................................. 10-465
Memorandum Dated Feb. 3, 2021, from Charles A. Therriault, Director of the NAIC SVO, and Eric Kolchinsky, Director of the NAIC Structured Securities Group (SSG) and Capital Markets Bureau, to Kevin Fry, Chair of the Valuation of Securities (E) Task Force, Regarding Proposed Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to Update the...
The Accounting Practices and Procedures (E) Task Force met March 23, 2021. The following Task Force members participated:

- Doug Slape, Chair, represented by Jamie Walker (TX); Trinidad Navarro, Vice Chair, represented by Rylynn Brown, Dave Lonchar and Tom Hudson (DE); Lori K. Wing-Heier and David Phifer (AK); Jim L. Ridling represented by Sheila Travis (AL); Evan G. Daniels represented by Kurt Regner (AZ); Alan McClain represented by Mel Anderson (AR); Ricardo Lara represented by Kim Hudson (CA); Andrew N. Mais represented by William Arflanis and Kathy Belfi (CT); Karima M. Woods represented by N. Kevin Brown (DC); David Altmairer represented by Carolyn Morgan and Virginia Christy (FL); Doug Ommen represented by Kevin Clark (IA); Dean L. Cameron represented by Eric Fletcher (ID); Stephen W. Robertson and Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Bill Clark (KY); Jams; J. Donelon represented by Caroline Fletcher, Melissa Gibson and Denise Gardner (LA); Gary D. Anderson represented by John Turchi (MA); Eric A. Cioppa and Vanessa Sullivan (ME); Anita G. Fox represented by Judy Weaver (MI); Grace Arnold represented by Kathleen Ort (MN); Chlora Lindley-Myers represented by Shannon Schmoeger and John Rehagen (MO); Troy Downing (MT); Mike Causey represented by Jackie Obusek (NC); Jon Godfried represented by Colton Schulz (ND); Bruce R. Ramge represented by Lindsay Crawford and Justin Schrader (NE); Chris Nicolopoulos represented by Patricia Gosselin and Doug Bartlett (NH); Russell Toal represented by Leatrice Geckler (NM); Juanita M. Allen represented by Kimberly Rankin and Melissa Greiner (PA); Elizabeth Kelleher Dwyer represented by Jack Broccoli and John Tudivino (RI); Raymond G. Farmer represented by Michael Shull (SC); Larry D. Deiter represented by Johanna Nickelson (SD); Carter Lawrence represented by Trey Hynke and Just Schrader (NE); Jonathon T. Pike represented by Jake Garn (UT); Scott A. White represented by Doug Stolte and David Smith (VA); Michael S. Pieciak represented by Karen Ducharme (VT); Mike Kreidler represented by Steve Drutz (WA); Rob Aftable represented by Amy Malm (WI); James A. Dorchin represented by Jamie Taylor (WV); and Jeff Rude, Linda Johnson and Doug Melvin (WY).

1. **Adopted its 2020 Fall National Meeting Minutes**

Ms. Walker directed the members to the Task Force’s 2020 Fall National Meeting minutes. Ms. Walker also noted that the Task Force met March 16, 2021, in regulator-to-regulator session, pursuant to paragraph 3 (discussion of specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff related to NAIC technical guidance of the Accounting Practices and Procedures Manual) of the NAIC Policy Statement on Open Meetings. No actions were taken during this meeting, and the discussion was limited to the Spring National Meeting agenda.

Ms. Malm made a motion, seconded by Ms. Obusek, to adopt the Task Force’s Nov. 19, 2020, minutes (see NAIC Proceedings – Fall 2020, Accounting Practices and Procedures (E) Task Force). The motion passed unanimously.


Mr. Bruggeman provided the report of the Statutory Accounting Principles (E) Working Group, which met March 15, except for 2019-24 related to levelized commissions which will be discussed separately. During this meeting, the Working Group adopted its Jan. 25, 2021; Jan. 6, 2021; Dec. 28, 2020; Dec. 18, 2020; Dec. 8, 2020; and Nov. 12, 2020, minutes. The interim minutes included the following adoptions to Appendix B—Interpretations (INTs) of statutory accounting principles (SAP):

a. **Extended INT 20-03: Troubled Debt Restructuring Due to COVID-19** and **INT 20-07: Troubled Debt Restructuring for Certain Debt Instruments Due to COVID-19** through Jan. 1, 2022, or the date that is 60 days after the date on which the national emergency concerning the COVID-19 outbreak terminates.

b. **INT 20-10: Reporting Nonconforming Credit Tenant Loans (CTLs)**: This INT allows nonconforming CTLs to continue to be reported on Schedule D Part 1 – Long-Term Bonds if filed with the NAIC Securities Valuation Office (SVO) by Feb. 15, 2021. The provisions within this INT and the ability to continue reporting nonconforming CTLs on Schedule D Part 1 with an SVO-assigned NAIC designation are limited to Oct. 1, 2021.

c. **INT 20-11: Extension of Ninety-Day Rule for the Impact of 2020 Hurricanes, California Wildfires and Iowa Windstorms**: This INT provides a 60-day extension from the 90-day rule for uncollected premium balances, bills
receivable and amounts due from agents and for policies directly affected by the noted events. This INT expires Feb. 28, 2021.

Mr. Bruggeman stated that the Working Group adopted the following nonsubstantive revisions to statutory accounting guidance:

a. **Statement of Statutory Accounting Principles (SSAP) No. 5R—Liabilities, Contingencies and Impairments of Assets, SSAP No. 72—Surplus and Quasi-Reorganizations** and **SSAP No. 86—Derivatives**: Revisions reject Accounting Standards Update (ASU) 2020-06, Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40), Accounting for Convertible Instruments and Contracts in an Entity’s Own Equity for statutory accounting. (Ref #2020-41)

b. **SSAP No. 25—Affiliates and Other Related Parties**: Revisions clarify that an ownership greater than 10% in a reporting entity results in a related party designation, regardless of any disclaimer of control or affiliation. Additionally, the agenda item requires disclosure of such instances and identification of an insurer’s ultimate controlling party, as requested by the Group Solvency Issues (E) Working Group. (Ref #2019-34)

c. **SSAP No. 26R—Bonds**:
   i. Revisions clarify that perpetual bonds are within the scope of SSAP No. 26R, and they are subject to the yield-to-worst concept. Additionally, perpetual bonds that possess a future call date will retain bond accounting—i.e., accounted for at amortized cost. However, if a perpetual bond does not possess a future call date, fair value accounting is required regardless of NAIC designation. (Ref #2020-22)
   ii. Revisions expand the current called bond disclosures to also include bonds terminated early through a tender offer. (Ref #2020-32)

d. **SSAP No. 32R—Preferred Stock** and **SSAP No. 86**: Revisions direct that publicly traded preferred stock warrants are in the scope of SSAP No. 32R, and they shall be reported at fair value. (Ref #2020-33)

e. **SSAP No. 43R—Loan-Backed and Structured Securities**: Revisions incorporate minor scope modifications to reflect recent changes to the Federal Home Loan Mortgage Corporation (Freddie Mac) Structured Agency Credit Risk (STACR) and Federal National Mortgage Association (Fannie Mae) Connecticut Avenue Securities (CAS) programs, which allow credit risk transfer securities from these programs to remain in the scope of SSAP No. 43R when issued through a real estate mortgage investment conduit (REMIC) structure. (Ref #2020-34)

f. **Appendix D—Nonapplicable GAAP Pronouncements**: Revisions reject ASU 2020-07, Not-for-Profit Entities (Topic 958): Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets as not applicable for statutory accounting. (Ref #2020-42)

g. **Appendix F—Policy Statements**: Revisions to the NAIC Policy Statement on Maintenance of Statutory Accounting Principles clarify the existing process regarding the Working Group’s issuance and adoption of accounting interpretations. (Ref #2020-39)

h. **Preamble**: Revisions clarify that while any state in which a company is licensed can issue prescribed practices, the prescribed practices directed by the domiciliary state: 1) shall be reflected in the financial statements filed with the NAIC; and 2) are the financial statements subject to independent audit requirements. (Ref #2020-40)

Mr. Bruggeman stated that the Working Group exposed the following nonsubstantive revisions to statutory accounting guidance:

a. **Exposed INT 21-01T: Statutory Accounting Treatment for Cryptocurrencies**, which clarifies that cryptocurrencies do not meet the definition of cash, and they are nonadmitted assets for statutory accounting. The Working Group requested comments on the level of interest and ownership of cryptocurrencies. (Ref #2021-05)
b. Revisions reject:

i. ASU 2020-08, Codification Improvements to Subtopic 310-20, Receivables – Nonrefundable Fees and Other Costs for statutory accounting. (Ref #2021-02)

ii. ASU 2021-02, Franchisors – Revenue from Contracts with Customers (Subtopic 952-606): Practical Expedient. (Ref #2021-07).

iii. ASU 2020-11, Financial Services—Insurance (Topic 944): Effective Date and Early Application (Ref #2021-08).

c. Exposed revisions to INT 20-01: ASU 2020-04 – Reference Rate Reform. INT 20-01 exposes a temporary (optional) expedient and exception guidance for ASU 2021-01, Reference Rate Reform (Topic 848): Scope with an expiration date of Dec. 31, 2022. The optional expedients would expand the current exceptions to allow for the continuation of the existing hedge relationship and thus not require hedge redesignation for derivative instruments affected by changes to interest/reference rates due to reference rate reform, regardless of whether they reference the London Interbank Offered Rate [LIBOR] or another rate that is expected to be discontinued. The exception in INT 20-01 would apply for affected derivatives used for discounting, margining or contract price alignment. (Ref #2021-01)

d. SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities: Exposed this agenda item with the intent to dispose without statutory edits. NAIC staff note that the long-standing, required statutory adjustments to SSAP No. 97, paragraph 8.b.iv. – Foreign Insurance SCA Entities could result in negative equity valuation, as assets held in a foreign subsidiary should not be valued in a more favorable manner than had they been held directly by the insurer. Industry comments are requested regarding detailed instances of negative value subsidiary, controlled and affiliated entities (SCAs). (Ref #2021-04)

e. SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities: Revisions propose data-captured templates for existing disclosures in SSAP No. 103R, which are currently only completed in narrative form. Data-capturing of such items will permit state insurance regulators to submit system inquiries to determine the extent to which reporting entities have transferred (sold), but still retain, a material participation with said assets. A blanks proposal will be concurrently exposed with the Working Group’s exposure. (Ref #2021-03)

f. SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act: Revisions include state Affordable Care Act (ACA) reinsurance programs, which are using Section 1332 waivers in the scope of SSAP No. 107. The revisions continue to follow the hybrid accounting approach for the state ACA programs, as they operate in a similar manner. (Ref #2021-09)

g. SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees: Re-exposed this agenda item to provide additional time for interested parties to develop a proposal for establishing accounting and reporting guidance for derivatives hedging the growth in interest for fixed indexed products. (Ref #2020-36)

Mr. Bruggeman stated that the Working Group exposed the following blanks proposals:

a. Re-exposed this agenda item for a concurrent exposure with the Blanks (E) Working Group. The Working Group is sponsoring blanks agenda item 2021-03BWG to modify the current General Interrogatory instructions and require that a distinct disaggregated product identifier be used for each product represented. The disaggregation will require that each separate account product filing or policy form be separately identified. The instructions will also indicate that companies may eliminate proprietary information. However, the elimination will still require the use of a unique reporting identifier. (Ref #2020-37)

b. Re-exposed this agenda item for a concurrent exposure with the Blanks (E) Working Group. The Working Group is sponsoring blanks agenda item 2021-03BWG to clarify reporting by each separate product filing or policy form and add product identifiers, specifically for pension risk transfer (PRT) and registered index linked annuity (RILA) transactions in the Separate Account General Interrogatories. (Ref #2020-38)
Mr. Bruggeman stated that the Working Group exposed the following editorial revisions (Ref #2021-06EP):

a. **SSAP No. 53—Property Casualty Contracts–Premiums**: Revisions retitle the statement to **SSAP No. 53—Property and Casualty Contracts–Premiums**.

b. **SSAP No. 97**: Revisions correct grammatical errors in paragraph 54.

c. **SSAP Glossary**: Revisions remove the footnote in the Glossary title and replace it as an opening paragraph with updated verbiage.

Mr. Bruggeman stated that the Working Group disposed agenda item 2020-35: SSAP No. 97 – Audit Opinions without statutory revisions, as the issue of nonadmittance due to the inability to quantify a departure from U.S. generally accepted accounting principles (GAAP) was not deemed prevalent. (Ref #2020-35)

Mr. Bruggeman stated that the Working Group received an update on the following projects and referrals:

a. Received an update that NAIC staff, industry and key state insurance regulators have made significant progress on agenda item 2019-21: SSAP No. 43R – Investment Classification Project. While discussions remain ongoing, it is anticipated that a public exposure will occur via an interim meeting prior to the Summer National Meeting. The exposure will include additional principle concepts on which investments are eligible for reporting on Schedule D as a bond.

b. Received an update that INT 19-02: Freddie Mac Single Security Initiative remains in full effect. The Freddie Mac Single Security Initiative remains an ongoing program, and it does not appear to be subject to termination in the foreseeable future.

c. Received an update on agenda item 2019-49: Retroactive Reinsurance Exception. This agenda item addresses a referral from the Committee on Property and Liability Financial Reporting (COPLFR) of the American Academy of Actuaries (Academy), which noted diversity in reporting regarding companies applying the retroactive reinsurance exception, which allows certain contracts to be reported prospectively. NAIC staff have held preliminary discussion with Casualty Actuarial and Statistical (C) Task Force members, with a preliminary recommendation that the premium and losses transferred under such transactions should be allocated to the prior Schedule P calendar year premiums and the losses allocated to the prior accident year incurred losses.

d. Received an update on the reporting and extinguishment of loans received from the Paycheck Protection Program (PPP). For statutory accounting, the authoritative guidance in **SSAP No. 15—Debt and Holding Company Obligations**, paragraph 11 provides that debt is recognized until extinguished, including formally being forgiven. In addition, per SSAP No. 15, paragraph 25 gains on termination of debt are recognized as capital gains.

e. Received an update on the Valuation of Securities (E) Task Force discussion regarding revisions to the **Purpose and Procedures Manual of the NAIC Investment Analysis Office** (P&P Manual) as coordination regarding the revisions to SSAP No. 105R—Working Capital Finance Investments adopted by the Working Group in May 2020 (agenda item 2019-25). At its Nov. 18, 2020, meeting, the Task Force directed a referral to the Working Group, which is still pending. NAIC staff anticipate addressing this referral when received.

f. Received an update on current U.S. GAAP exposures/invitations to comment, noting that no comments by the Working Group are planned during the exposure periods.

Mr. Bruggeman stated the public comment period for all exposed agenda items ends April 30.

Mr. Bruggeman made a motion, seconded by Ms. Rankin, to adopt the Working Group’s report except for agenda item 2019-24 on levelized commission, which will have a separate vote (Attachment One). The motion passed unanimously.

3. **Adopted Agenda Item 2019-24**

Mr. Bruggeman provided an overview of Statutory Accounting Principles (E) Working Group agenda item 2019-24 regarding levelized commission, which affects **SSAP No. 71—Policy Acquisition Costs and Commissions**. He stated that the Working Group has been discussing this item since August 2019, when it was brought to the Working Group by a domiciliary state. Mr.
Bruggeman stated that after six public discussions, the nonsubstantive revisions that clarify the guidance in SSAP No. 71 regarding levelized commissions were adopted on March 15, 2021, with a Dec. 31, 2021, effective date. Thirteen Working Group members voted in favor of adoption, and one member was opposed. At the March 15 meeting, the Working Group affirmed the nonsubstantive classification of these revisions as consistent with the original intent of SSAP No. 71. In addition, the Working Group exposed a new annual statement general interrogatory to identify the use of a third party for the payment of commission expenses, which will be concurrently exposed with the Blanks (E) Working Group.

Mr. Bruggeman stated that both U.S. GAAP and SAP would calculate acquisition costs in a similar manner. However, one of the major financial reporting differences between SAP and GAAP is that GAAP capitalizes acquisition costs and expenses them over time to match revenue and expenses. SAP expenses policy acquisitions costs as incurred.

Mr. Bruggeman stated that at the heart of this issue is that a small number of reporting entities are using third parties to pay their sales commission costs and not recognizing the full liability of what is in essence a loan to repay the third parties as required under SSAP No. 71. He said that the Working Group has had extensive discussion on this topic and has noted that the revisions clarify the long-standing principles in SSAP No. 71, which have existed since even prior to codification. He stated that the revisions were classified as nonsubstantive because the revisions emphasize the original principles regarding funding agreements and the impact to a minor number of companies do not determine the classification of the revisions.

Mr. Bruggeman noted that state insurance regulators and consumer representative also voiced concerns about the illusory surplus and unlevel playing field such arrangements create. He stated that because of the unfair competitive advantages that are perceived, the Working Group was not in favor of grandfathering the practices. He noted that the Working Group did discuss that companies could have discussions with their domiciliary states regarding obtaining a permitted practice for phasing in the financial impact. He stated that a permitted practice approach was favored because the impact to the affected companies may vary.

Ms. Fletcher noted that Commissioner James J. Donelon could not attend the meeting, but he wanted his comments that this is a substantive change noted and also that he is in favor of a phase-in period. Mr. Snowbarger noted that Oklahoma also supports the comments from Louisiana.

Lynn Kelley (Delaware Life) stated that their position is also that the revisions are substantive and that they appreciate the time that the Working Group has spent discussing this issue even if not all of the edits they submitted were incorporated. She also stated support for an effective date at least as late as Dec. 31, 2021.

Elly Nettleton (Guggenheim Life and Annuity) highlighted two points from their prior comment letters: 1) levelized commissions are not a new concept and date back several decades. She noted that a 2010 U.S. Securities and Exchange Commission (SEC) complaint against another carrier identified levelized commissions as a common practice in the industry. She said Guggenheim is not aware that the accounting treatment was determined not to be in accordance with statutory accounting principles; and 2) traditional commissions such as those tied to policy persistency are carved out of the proposals. Ms. Nettleton said Guggenheim believes it is a dangerous precedent to remove persistency as a factor in the accrual of commissions as it is a key insurance element.

Mr. Bruggeman noted that similar comments as Ms. Nettleton’s were made at the Working Group. He stated that the Working Group did hear the comments but did not agree with them.

Thomas Considine (National Council of Insurance Legislators—NCOIL) stated that NCOIL members feel strongly that the revisions are substantive but are willing to put that aside and do not feel the need to debate that classification again at this time. He stated that this is a practice that has been going on for decades. He stated that to implement this change during a period of great economic turmoil seems not only short-sighted, but also it is dangerous to require entities to make such a change in a period of a year. He stated that NCOIL recommends a significant phase-in period with a proposed effective date of Dec. 31, 2025. He noted prior Working Group discussions have recommended that reporting entities seeking a phase-in period should seek a permitted practice from their domiciliary regulators. He stated that a permitted practice does not reflect positively on the state granting the practice or the reporting entity receiving the practice. He stated that accreditation reviews note the permitted practices granted by a jurisdiction. He stated that the most fair and equitable solution and a way to avoid the debate of change classification is to add a four- or five-year phase-in.

Mr. Bruggeman stated that funding agreements to levelized commission costs are not prohibited. He said the issue is that the full liability for the funding agreement must be recognized for the inherent loan. In other words, it is a financing arrangement; it does not delay the timing of recognition of the acquisition costs. He stated that a permitted practice may not have a positive
perception. However, permitted practice disclosure requirements allow state insurance regulators to understand the surplus impact of the arrangement. He stated that a permitted practice provides transparency and noted that if there were any decisions to extend the effective date beyond Dec. 31, 2021, there would need to be a disclosure of the impact. Ms. Walker agreed, noting that consistency, meaning the ability to compare reporting entities’ financial positions, is a fundamental concept that statutory accounting is based on. She noted its importance for solvency regulation.

Mr. Considine noted that to address Mr. Bruggeman’s point about state insurance regulators’ information, he is confident that if there were a four- or five-year phase-in, legislators would be supportive of a reasonably tailored data call. Mr. Rehagen asked if Mr. Considine envisioned a confidential data call or one that would be publicly produced. Mr. Considine indicated he assumed if it were for the state insurance regulators, then such a data call would be confidential. However, he said NCOIL would be open to discussion. Mr. Bruggeman stated his intent was for a disclosure to be part of the public statutory accounting filing.

Mr. Stolte stated that the Task Force is discussing noncompliant statutory accounting by a handful of companies. He stated that in 1991, Virginia had an insurance receivership of a large life insurance company that had a deferred commission funding arrangement. He said that the insurer had not booked the liability, but when the company was put into receivership, the funding entity/financier filed with the receivership a request for payment of $16 million. He said that the reporting entity prior to the receivership was reporting $120 million in surplus, but true surplus ended up being approximately $4 million. He said he disagreed with the statement that what the handful of companies are doing is an acceptable SAP practice. He said it is noncompliance with statutory accounting in SSAP No. 71, and also with the statutory accounting guidance that existed even prior to codification. He said from a level playing field perspective, he does not want to be forced to approve such agreements for his companies to be able to compete with reporting entities employing this practice. He stated that not recording the full liability for the funding agreements creates illusory surplus. He stated that if a reporting entity needs more time to implement the revisions, a permitted practice is what should be employed. He noted that he received notification of more than 100 permitted practices in an average year. He stated that the permitted practices are designed to provide transparent disclosure for all state insurance regulators.

Mr. Considine stated that what Mr. Stolte is terming “noncompliance” has been accepted in the regulatory community for 20 years. He said if reporting entities have been doing so for 20 years, it seems unreasonable to require a change in one year. Mr. Stolte said that in Virginia, they have not accepted such practices. He noted that there may be some that they were unaware of, but they do not view it as an acceptable practice. He stated that this has been noted as problematic in a formal examination report, and he respectfully disagrees with Mr. Considine’s statement that it was an acceptable practice. Ms. Walker also noted that she has been a Texas state insurance regulator for 20 years and is not aware of any entities that are using funding agreements to defer the recognition of acquisition costs. She noted that she would also take exception to doing so if it were identified in an examination or other regulatory review.

Brendon Bridgeland (Center for Insurance Research—CIR) stated support for the proposal as adopted by the Working Group. He stated that one of the top priorities for state insurance regulators was ensuring that the insurers are solvent. He stated that part of that is also ensuring that there is a level playing field. He stated that in this case, there are a handful of companies using a technique that, by their own admission, is enhancing surplus. He noted that as a consumer advocate, he does not want to see insurers have illusory surplus.

Mr. Bruggeman made a motion, seconded by Mr. Stolte to adopt the nonsubstantive revisions to SSAP No. 71 with a Dec. 31, 2021, effective date as adopted by the Working Group (Attachment One-Q). The motion passed with 41 in favor and the states of Louisiana and Oklahoma opposed.

Ms. Walker stated that agenda item 2019-24 will next be discussed by the Financial Condition (E) Committee, which is scheduled to meet April 13.


Mr. Garn provided the report of the Blanks (E) Working Group, which met March 16. He stated that the Working Group adopted its Dec. 16, 2020, minutes, which included the following action:

a. **Adopted four blanks proposals:** 1) 2020-28BWG – remove Note 22; 2) 2020-29BWG – remove a line category from the investment schedules; 3) 2020-30BWG – move an interrogatory question from the annual blank to the quarterly blank; and 4) 2020-31BWG – changes to the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibits.
b. Exposed seven proposals for a 60-day public comment period ending Feb. 16.

c. Adopted its editorial listings.

Mr. Garn stated that the Working Group adopted its editorial listing and the following seven proposals:

a. 2020-32BWG – Add a new Health Care Receivables Supplement to the Life/Fraternal Annual Statement that adds Exhibit 3 and Exhibit 3A from the Health Annual Statement to the Life/Fraternal annual filings. Add a guidance document reference to Exhibit 3A of the Health Annual Statement.

b. 2020-33BWG – Modify Annual Statement Lines (ASLs) used on Underwriting and Investment (U&I) Exhibits, State Page and Insurance Expense Exhibit (IEE). Change Health ASL categories used in Property to be consistent with other statement types. Update ASL references used in crosschecks. Update definitions used in the appendix for the Health ASLs.

c. 2020-34BWG – Add definitions for the Occupational Accident, Fiduciary Liability, Premises and Operations (OL&T and M&C), Professional Errors and Omissions Liability, Kidnap & Ransom Liability and Tuition Reimbursement Plans products to the appropriate Line of Business in the appendix.

d. 2020-35BWG – Expand the number of characters used from seven to 10 in the investment line categories for Schedules D, DA, DL and E excluding Schedule D, Part 6 (Sections 1 and 2) and Schedule E (Part 1 and 3). Add line categories for Unaffiliated Certificates of Deposit and Exchange Traded Funds (ETFs). Split the line categories for Mutual Funds, Investment Unit Trusts and Closed-End Funds into lines indicating if the fund has been assigned a designation by the SVO. Make changes to Summary Investment Schedule, Summary by Country and Schedule D, Part 1A (Section 1 and Section 2) to reflect the additional line categories.

e. 2020-36BWG – Modify the General Schedules Investment Instructions and Schedule DB General Instructions to reflect treatment of publicly traded stock warrants as being in the scope of SSAP No. 30R—Unaffiliated Common Stock or SSAP No. 32R and reporting as common and preferred stock (SAPWG 2020-33).

f. 2020-37BWG – Add a new Schedule Y, Part 3 to capture all entities with ownership greater than 10%, the ultimate controlling parties of those owners and other entities that the ultimate controlling party owns (SAPWG 2020-34).

g. 2020-38BWG – Make changes to the Accident and Health Policy Experience Exhibit by adding new columns, removing lines distinguishing with and without contract reserves, adding some new product lines, eliminating summary tables, changing the date that the exhibit is due and having it reported by state.

Mr. Garn stated that the Working Group exposed five new proposals for a six-week public comment period ending April 27 and received a memorandum from the Valuation of Securities (E) Task Force regarding the addition of two new residential mortgage-backed securities (RMBS)/commercial mortgage-backed securities (CMBS) administrative codes.

Mr. Garn made a motion, seconded by Mr. Eft, to adopt the report of the Blanks (E) Working Group (Attachment Two). The motion passed unanimously.

Having no further business, the Accounting Practices and Procedures (E) Task Force adjourned.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force met March 15, 2021. The following Working Group members participated: Dale Bruggeman, Chair (OH); Carrie Mears and Kevin Clark, Vice Chairs (IA); Shelia Travis (AL); Kim Hudson (CA); William Arfanis and Kathy Belfi (CT); Tom Hudson (DE); Eric Moser, Cindy Andersen and Kevin Fry (IL); James J. Donelon, Stewart Guerin, Melissa Gibson and Caroline Fletcher (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); Melissa Greiner and Kimberly Rankin (PA); Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI). Also participating was: Glen Mulready (OK).

1. **Adopted its Jan. 25, 2021; Jan. 6, 2021; Dec. 28, 2020; Dec. 18, 2020; Dec. 8, 2020; and Nov. 12, 2020 Minutes**

Ms. Malm made a motion, seconded by Mr. Kim Hudson, to adopt the Working Group’s Jan. 25, 2021 (Attachment One-A); Jan 6, 2021 (Attachment One-B); Dec. 28, 2020 (Attachment One-C); Dec. 18, 2020 (Attachment One-D); Dec. 8, 2020 (Attachment One-E); and Nov. 12, 2020 (see NAIC Proceedings – Fall 2020, Accounting Practices and Procedures (E) Task Force, Attachment One) minutes. The motion passed unanimously.

The Working Group met in regulator-to-regulator session on March 9. This regulator session was pursuant to the NAIC Open Meetings Policy paragraph 3 (discussion of specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff related to NAIC technical guidance of the Accounting Practices and Procedures Manual). No actions were taken during this meeting and the discussion was limited to its March 15 agenda.

2. **Adopted Non-Contested Positions**

The Working Group held a public hearing to review comments (Attachment One-F) on previously exposed items.

Mr. Bartlett made a motion, seconded by Ms. Weaver, to adopt the statutory accounting revisions detailed below as non-contested statutory accounting revisions. Included in this motion was the disposal of agenda item 2020-35: SSAP No. 97 – Audit Opinions. The motion passed unanimously.

a. **Agenda Item 2020-32**

Mr. Bruggeman directed the Working Group to agenda item 2020-32: SSAP No. 26R – Disclosure Update (Attachment One-G). He stated that this nonsubstantive agenda item expands a current disclosure element in Statement of Statutory Accounting Principles (SSAP) No. 26R—Bonds to include securities terminated early through a tender offer. This disclosure will require securities that are sold, redeemed or disposed of through either a call or tender offer to be specifically identified.

b. **Agenda Item 2020-33**

Mr. Bruggeman directed the Working Group to agenda item 2020-33: SSAP No. 32R – Publicly Traded Preferred Stock Warrants (Attachment One-H). He stated that this nonsubstantive agenda item expands the scope of SSAP No. 32R—Preferred Stock to include publicly traded preferred stock warrants, and it will require these warrants to be reported at fair value.

c. **Agenda Item 2020-34**

Mr. Bruggeman directed the Working Group to agenda item 2020-34: SSAP No. 43R – GSE CRT Program (Attachment One-I). He stated that this nonsubstantive agenda item incorporates modifications to reflect recent changes to the Freddie Mac Structured Agency Credit Risk (STACR) and Fannie Mae Connecticut Avenue Securities (CAS) programs. The modifications will allow credit risk transfer (CRT) securities from these programs to remain in scope of SSAP No. 43R—Loan-Backed and Structured Securities when issued through a real estate mortgage investment conduit (REMIC) trust structure.
d. **Agenda Item 2020-35**

Mr. Bruggeman directed the Working Group to agenda item 2020-35 (Attachment One-J). He stated that this nonsubstantive agenda item was recommended for disposal without changes to statutory accounting, as feedback from interested parties indicated that the nonadmittance of an SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities 8.b.iii entity (non-insurance subsidiary, controlled and affiliated [SCA]) due to the inability to quantify a U.S. generally accepted accounting principles (GAAP) departure was not prevalent. Accordingly, additional admittance exceptions are not deemed to warrant further consideration.

e. **Agenda Item 2020-41**

Mr. Bruggeman directed the Working Group to agenda item 2020-41: ASU 2020-06, Convertible Instruments (Attachment One-K). He stated that this nonsubstantive agenda item rejects Accounting Standards Update (ASU) 2020-06 in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets, SSAP No. 72—Surplus and Quasi-Reorganizations, and SSAP No. 86—Derivatives, as this ASU references accounting models for convertible debt instruments not reflected in statutory accounting.

f. **Agenda Item 2020-42**

Mr. Bruggeman directed the Working Group to agenda item 2020-42: ASU 2020-07, Presentation and Disclosures by Not-for-Profit Entities (Attachment One-L). He stated that this nonsubstantive agenda item rejects ASU 2020-07 as not applicable for statutory accounting. Reference to this ASU will be reflected in Appendix D—Nonapplicable GAAP Pronouncements.

3. **Reviewed Comments on Exposed Items**

The Working Group held a public hearing to review comments (Attachment One-F) on previously exposed items.

a. **Agenda Item 2020-22**

Mr. Bruggeman directed the Working Group to agenda item 2020-22: Accounting for Perpetual Bonds. Jim Pinegar (NAIC) stated that this agenda item addresses the accounting treatment for perpetual bonds in SSAP No. 26R. This agenda item incorporates guidance to clarify that the premium associated with a perpetual bond that has an effective call option shall be amortized using the yield-to-worst concept. Perpetual bonds that do not have an effective call option are to be reported at fair value. The proposed revisions to the exposure include clarification regarding the use of the yield to worst concept provided in the interested parties. Diane Bellas (Allstate), representing interested parties, stated that interested parties support adoption of the proposed edits to SSAP No. 26R, and further exposure is not necessary.

Mr. Kim Hudson made a motion, seconded by Mr. Bartlett, to adopt the nonsubstantive revisions to SSAP No. 26R, modified from the exposure to include proposed edits received from interested parties during the exposure period (Attachment One-M). The motion passed unanimously.

b. **Agenda Items 2020-37 and 2020-38**

Mr. Bruggeman directed the Working Group to agenda item 2020-37: Separate Account Product Mix and agenda item 2020-38: Pension Risk Transfer Disclosure. Mr. Pinegar stated that these agenda items were drafted at the request of state insurance regulators due to the recent growth of pension risk transfers (PRTs) and registered indexed linked annuities (RILAs). These agenda items initially requested input on the degree of product identifying details in the separate account blanks. Mr. Pinegar stated that as a result of the prior exposure, interested parties suggested general interrogatory reporting of PRTs and RILAs, and state insurance regulators have requested additional reporting granularity in the separate account general interrogatories to ensure consistent reporting of products. He stated that based on these comments, a blanks proposal has been developed to add PRT and RILA reporting categories and modify the general interrogatory instructions to require disaggregated product reporting, using unique product identifiers for each product represented. He stated that aggregation in reporting can still occur if the products are under the same product filing or policy form; otherwise, the instructions require disaggregation in reporting.

Mr. Bruggeman stated that as noted in the meeting materials, while disaggregated reporting is proposed to be required, companies will have the ability to eliminate proprietary information in reporting.
Ms. Malm made a motion, seconded by Ms. Weaver, to expose agenda item 2020-37 and agenda item 2020-38 with detail on the proposed general interrogatory reporting changes. The motion passed unanimously. It was noted that the blanks proposal is expected to be concurrently exposed by the Blanks (E) Working Group.

c. **Agenda Item 2020-39**

Mr. Bruggeman directed the Working Group to agenda item 2020-39: Interpretation Policy Statement. Mr. Pinegar stated that this agenda item was drafted in response to questions received last year as the Working Group and the Accounting Practices and Procedures (E) Task Force considered Interpretation (INT) 20-08: COVID-19 Premium Refunds, Limited-Time Exception, Rate Reductions and Policyholder Dividends. The agenda item clarifies the voting requirements of the Working Group for INTs that do or do not amend, supersede or conflict with existing statutory accounting principles (SAPs). Additionally, it clarifies existing options of the Working Group, such as the deferral of adoption until the INT has had an opportunity to be reviewed by the Task Force. Mr. Pinegar stated that interested parties responded with a few edits, primarily to clarify the purpose or ability to issue INTs that conflict with SAPs. He stated that the guidance proposed for adoption does integrate a majority of the edits proposed by interested parties, except for edits that would have restricted the issuance of INTs to emergency situations. He stated that those edits would have restricted the Working Group’s current ability to make INTs for time-sensitive, but not emergency items, such as the issuance of INT 20-01: ASU 2020-04 - Reference Rate Reform.

Michael M. Monahan (American Council of Life Insurers—ACLI) stated that the ACLI agrees with the edits as proposed by NAIC staff, and an additional exposure of this agenda item is not necessary.

Mr. Kim Hudson made a motion, seconded by Mr. Bartlett, to adopt nonsubstantive revisions, modified from the exposure with edits as proposed by NAIC staff and interested parties, to the NAIC Policy Statement on Maintenance of Statutory Accounting Principles regarding the issuance and adoption of accounting interpretations (Attachment One-N). The motion passed unanimously.

d. **Agenda Item 2020-40**

Mr. Bruggeman directed the Working Group to agenda item 2020-40: Prescribed Practices. Julie Gann (NAIC) stated that this agenda item was drafted in response to questions received last year as the Working Group considered INT 20-08. She stated that this agenda item clarifies that while any state in which a company is licensed can issue prescribed practices, the prescribed practices directed by the domiciliary state shall be reflected in the financial statements filed with the NAIC, and they are the ones subject to independent audit requirements. The revisions clarify that non-domiciliary states may require supplemental financial information that details different accounting practices pursuant to the prescribed practices of the non-domiciliary state. Ms. Gann stated that in response to comments received from interested parties, references to financial statements in both the agenda item and the proposed authoritative guidance have been corrected to reflect supplemental financial information when referring to submissions to the non-domiciliary state.

Keith Bell (Travelers), representing interested parties, agreed that the edits proposed by NAIC staff reflect the request of interested parties, and an additional exposure of this agenda item is not necessary.

Mr. Smith made a motion, seconded by Mr. Kasinow, to adopt nonsubstantive revisions, modified from the exposure to incorporate edits as proposed by NAIC staff and interested parties, to the Preamble Implementation Questions and Answers regarding prescribed accounting practices. (Attachment One-O). The motion passed unanimously.

e. **Agenda Item 2020-36**

Mr. Bruggeman directed the Working Group to agenda item 2020-36: Derivatives Hedging Fixed Indexed Products. Ms. Gann stated that this agenda item proposes the development of new substantive guidance for the accounting and reporting of derivatives that effectively hedge the growth in interest credited for fixed indexed products that are reported in the general account. Interested parties provided a comment letter requesting additional time for the development of a proposal. Ms. Gann stated that NAIC staff recommend re-exposure of this agenda item with the direction to work with interested parties in the development of applicable guidance.
Rosemarie Albrizio (Equitable), representing interested parties, stated that interested parties appreciates the opportunity to jointly collaborate on this project, and now that year-end reporting has concluded, its staff have the capacity to focus on this proposal.

Mr. Kim Hudson made a motion, seconded by Ms. Weaver, to re-expose agenda item 2020-36 and direct NAIC staff to continue to collaborate with industry on a proposal to account for derivatives that effectively hedge the growth in interest credited for fixed indexed products. The motion passed unanimously.

4. Reviewed Comments on Exposed Items

a. Agenda Item 2019-34

Mr. Bruggeman directed the Working Group to agenda item 2019-34: Related Parties, Disclaimer of Affiliation and Variable Interest Entities. Jake Stultz (NAIC) stated that this agenda item proposes several nonsubstantive revisions to SSAP No. 25—Affiliates and Other Related Parties. He stated that the agenda item clarifies: 1) the definition of related parties; 2) that a non-controlling ownership over 10% results in a related party classification, regardless of any disclaimer of control or affiliation; and 3) that a disclaimer of control or affiliation does not eliminate the classification as a related party for the disclosure of material transactions, as is required under SSAP No. 25. This agenda item also rejects several Financial Accounting Standards Board (FASB) ASUs regarding variable interest entities. Mr. Stultz stated that the agenda item requires increased disclosure of related parties, and it will provide information on minority ownership interests, as well as significant relationships between minority owners and other U.S. domestic insurers and groups. He stated that in collaboration with interested parties, a few additional minor modifications have been proposed, primarily clarifying that ownership includes both direct or indirect ownership. He stated that in conjunction with the Working Group’s agenda item, the Blanks (E) Working Group has a concurrent exposure that includes a new Schedule Y, Part 3, which will be considered for adoption pending the action taken by the Working Group.

Mr. Bell stated that Travelers agrees that the edits proposed by NAIC staff are consistent with the requests of interested parties, and an additional exposure of this agenda item is not necessary.

Mr. Bartlett made a motion, seconded by Ms. Travis, to adopt the exposed nonsubstantive revisions to SSAP No. 25, with modifications to incorporate the minor edits as proposed by NAIC staff and interested parties (Attachment One-P). The motion passed unanimously.

b. Agenda Item 2019-24

Mr. Bruggeman directed the Working Group to agenda item 2019-24: Levelized and Persistency Commissions. Robin Marcotte (NAIC) stated that the Working Group has been discussing this topic since August 2019 with this being the sixth public discussion. This agenda item was drafted in response to a specific state insurance regulator request to address an accounting practice identified during a financial examination. Ms. Marcotte stated that a few insurers are utilizing a disputed practice by using third parties to pay policy acquisition costs, and they are not recognizing the full liability to repay those third parties. Not recognizing the full liability to repay the parties who are paying acquisition costs on an insurer’s behalf is inconsistent with the guidance in SSAP No. 71—Policy Acquisition Costs and Commissions. SSAP No. 71, which has been in place prior to 1998, provides statutory accounting guidance and identifies such agreements as funding agreements, which require full liability recognition. Ms. Marcotte stated that in November 2020, the Working Group exposed additional edits to clarify that the SSAP No. 71 updates would be effective immediately upon adoption and apply to all contracts that are in effect as of the date of adoption. The Working Group has also previously determined that the revisions to SSAP No. 71 have met the due process for either a substantive or nonsubstantive revision; however, it concluded that the revisions are to be classified as nonsubstantive. Ms. Marcotte stated that the Working Group has previously reiterated that under the NAIC Policy Statement on Maintenance of Statutory Accounting Principles, it is not the impact of a change on an individual entity that determines whether a change is substantive or nonsubstantive but whether the revision is consistent with the original intent of the SSAP. In addition, the Working Group directed the development of an issue paper to document the historical discussion on this topic.

Ms. Marcotte stated that NAIC staff are recommending that the Working Group: 1) adopt the previously exposed updates to SSAP No. 71 after consideration regarding the effective date; and 2) concurrently expose with the Blanks (E) Working Group a proposal to incorporate a new general interrogatory to assist with the identification of the use of funding agreements. She stated that NAIC staff have drafted an issue paper to document the historical discussions regarding this topic. She stated that
an issue paper is not authoritative, so there is no need to delay the SSAP No. 71 effective date for the adoption of the issue paper. She recommended that the Working Group direct NAIC staff to update the issue paper for actions from this meeting and determine when to expose the issue paper. Additionally, NAIC staff did not recommend further edits to SSAP No. 71, as revisions proposed by interested parties and other commentors either do not concur with the principles of SSAP No. 71 or have been rejected by the Working Group in prior discussions. Mr. Bruggeman stated that NAIC staff have provided a summary of comments received, which includes a response to each position. Accordingly, NAIC staff are not recommending additional modifications.

Commissioner Mulready stated that he had provided a comment letter to the NAIC president and the Financial Condition (E) Committee. He inquired as to whether actions taken by the Working Group regarding this project would go through the complete NAIC committee process, including reporting to the Accounting Practices and Procedures (E) Task Force and the Financial Condition (E) Committee and review by the Executive (EX) Committee and Plenary. Mr. Bruggeman stated that due to the controversial nature of this topic, this agenda item will be specifically considered through all levels of the committee process.

Commissioner Mulready further inquired regarding the expense recognition and payment of cashflows for using a third party to pay policy acquisition costs compared to insurers who directly pay commission expense. Mr. Bruggeman stated that traditional life insurance policies typically have a larger commission in the first year the policy is written. Through the use of a third party, some insurers have used a levelized repayment plan, so the first-year commission is repaid over several years. Additionally, the immediate expense recognition for this first year commission, as is required under SSAP No. 71, is not being properly recognized by some insurers in the year of acquisition. As a third party has remitted funds on behalf of an insurer, the insurer needs to properly recognize the loan as a liability. Commissioner Mulready queried about lapse risk, which is a common element built into these financing agreements. Mr. Bruggeman commented that lapse risk cannot be transferred to a noninsurance entity; and SSAP No. 71 still requires the liability to be recognized, even if repayment to the third party is not guaranteed. Mr. Bruggeman further stated that by not recognizing the full commission financing liability, an insurance company is asserting a 100% lapse rate, which is not an appropriate assumption and not consistent with the reserving methodology used for these products.

Elly Nettleton (Guggenheim) stated that levelized commissions are not a new concept. She noted that a 2010 U.S. Securities and Exchange Commission (SEC) complaint against another carrier notes that levelized commissions were common practice before Issue Paper No. 71 was finalized. She stated that the concept of persistency remains a concern, as Guggenheim believes expense recognition will occur earlier than has traditionally been required. She stated that Guggenheim does feel it is a dangerous practice to remove persistency in the treatment of levelized commission. Mr. Bruggeman stated that the concepts regarding traditional persistency commission are not a part of the proposed edits, as this agenda item is to clarify that initial acquisition costs should not be deferred through the use of a funding agreement.

Mr. Stolte stated that in 1991, Virginia had an insolvency in which the company participated in a structure where it utilized a levelized commission financing arrangement and did not properly recognize a liability for the amounts paid by the third party. However, as the insurer was liquidated, the third-party financier sought reimbursement for commission amounts previously forwarded on behalf of the insurer. Mr. Stolte stated that the insurer had not recorded the full amount of the liability, and this overstated surplus. He stated that if these amounts due are not recorded, they are in essence off book, unrecorded liabilities. He stated that the concept of recognizing commission expenses when incurred has been a long-standing concept of statutory accounting, which was noted even prior to codification. He noted that acquisition costs are expensed as incurred upfront.

Commissioner Donelon responded that the insurer referenced by Mr. Stolte did a levelized commission practice; however, he perceived the accounting practice was fully transparent, and the $16 million amount of the off-balance sheet liability only represented a fraction of the $120 million insolvency. He stated that earlier exposures of this item, involved other large life insurers; however their earlier concerns appear to have been accommodated. He inquired regarding the nature of this accommodation. Mr. Bruggeman stated that the referenced was clarification that true persistency commissions—i.e., subsequent year commissions—were not intended to be captured in the scope of levelized commissions revisions in SSAP No. 71. He said the initial revisions that were perceived by the broader insurance industry as affecting traditional persistency commission and the Working Group subsequently clarified that that was not the intent of the revisions. Ms. Gann stated that SSAP No. 71 is a common area SSAP, so it is applicable to all insurer and product types. She stated that the intent of SSAP No. 71 revisions is to capture initial acquisition costs, not traditional persistency commissions as are common in many insurance products.
Thomas B. Considine (National Council of Insurance Legislators—NCOIL) stated that NCOIL believes that the changes proposed are substantive in nature and the timing of an adoption is less than prudent, especially in light of the current economic environment. He noted that he believes the revisions will have adverse capital consequences on some companies. Companies utilizing levelized commission structures have done so for decades, and in conjunction with this requiring a significant financial impact, NCOIL would recommend a four or five-year phase-in of expense recognition. Mr. Stolte stated that in response to a multi-year phase-in request, insurers affected could request a permitted practice from their state of domicile. In doing so, a multi-year phase-in could be granted; however, the financial and capital impact could be appropriately disclosed. Mr. Considine stated that permitted practices are not viewed as favorably as uniform treatment, and this would not be a preferred solution.

Lynn Kelley (Delaware Life), on behalf of interested parties, stated that they do not agree with the proposed edits, and they believe the edits are substantive in nature. She stated that interested parties believe that their accounting practices have been in compliance with SSAP No. 71 and have been subject to numerous insurance exams and independent financial audits. If adopted by the Working Group, an effective date no earlier than Dec. 31, 2021, is requested. She stated her agreement with a multi-year phase-in.

Brendan Bridgeland (Center for Insurance Research—CIR), NAIC consumer representative, stated that the most important function of statutory accounting is to ensure solvency and a level playing field among similar insurers. He stated that an insurer’s financial statements should reflect capital available to pay policyholder claims and not include off-balance sheet liabilities. Despite this requiring material adjustments to a few insurers, he stated that adoption was recommended to ensure that financial statements appropriately reflect an insurer’s financial position. He stated that deferring the recognition of commissions is what is maintaining a company in the appropriate risk-based capital (RBC) range, then the company may warrant additional scrutiny for other areas as well.

Mr. Bruggeman stated that as the edits proposed do not change the original intent of SSAP No. 71, he views the edits as nonsubstantive in nature. He stated that the concept of requiring immediate expense recognition of initial acquisition costs meets the spirit of statutory accounting concepts, as well as the concept of conservatism as referenced in the preamble. Commissioner Donelon stated that he believes this issue to be substantive in nature, even if it is not in the technical accounting sense. He indicated that the reporting entity that contacted him indicated that it will not have a materially adverse impact on them. However, he has been told that there are reporting entities that will have a significant financial impact on some small companies, and it will jeopardize members of the ACLI and the National Alliance of Life Companies (NALC). He stated recommendation for grandfathering of existing practices or a multi-year phase-in of any recognition requirements. He stated his agreement with Mr. Considine that a permitted practice is not preferred. Mr. Smith stated that when referencing the definitions of substantive versus nonsubstantive in the Accounting Practices and Procedures Manual (AP&P Manual), the exposed edits are nonsubstantive in nature.

Commissioner Mulready stated that this practice has been in place for decades, and to classify this as nonsubstantive signifies to him that all prior insurance exams and independent audits are incorrect. Ms. Andersen stated that the proposed edits are only clarifying in nature, as they do not change the intent of SSAP No. 71. She stated that this practice has only been employed by a small subset of insurance entities, and it results in liabilities that are not recorded in the financial statements. Mr. Stolte stated that commission financial arrangements are difficult to discover; in the prior insolvency example referenced by Mr. Stolte, it was not until the company was in receivership that the issue was discovered. He noted that such arrangements create illusory surplus and violate the concepts of statutory accounting. He noted that audits do not review every single contract.

Mr. Smith made a motion, seconded by Mr. Kim Hudson, to classify the edits as nonsubstantive in nature. The motion passed, with Louisiana voting opposed.

Mr. Bruggeman stated that nonsubstantive agenda items are generally effective immediately; however, due to the nature of this topic, it will need to be approved by the Accounting Practices and Procedures (E) Task Force, the Financial Condition (E) Committee, and the Executive (EX) Committee and Plenary. With the Executive (EX) Committee and Plenary not meeting until the Summer National Meeting, the earliest this adoption could take effect is likely the third quarter of 2021. Mr. Smith stated that due to the length that this agenda item has been discussed, they would support an immediate effective date. Ms. Belfi, Mr. Fry, Mr. Clark and Mr. Kim Hudson stated that due to the likelihood of a significant financial impact combined with the requirement for adoption by the Executive (EX) Committee and Plenary, a Dec. 31, 2021, effective date is recommended. In an inquiry from Mr. Bruggeman, no one opposed to a Dec. 31, 2021, effective date.
Ms. Gann stated that in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors, as this agenda item directs that any adjustments be accounted for as a change in accounting principle, the effective date will not have a material impact, as any required cumulative adjustments calculated as of Jan. 1, 2021, will impact unassigned funds (surplus). Mr. Bruggeman stated in response to a query that upon adoption, insurers will be required to record a liability for outstanding amounts due to a third-party funding agent as a cumulative effect adjustment to surplus as of Jan. 1. He noted that activities throughout the year after Jan. 1 are recorded through income.

Mr. Kim Hudson made a motion, seconded by Mr. Smith, to adopt the previously exposed nonsubstantive edits to SSAP No. 71 with a Dec. 31, 2021, effective date discussed in the meeting (Attachment One-Q). Included in this motion was a recommendation to support a concurrent Blanks (E) Working Group agenda item requiring a general interrogatory to identify, in certain instances, companies who use third parties to pay commission expenses. The motion passed, with Louisiana voting opposed.

Ms. Marcotte asked whether the Working Group wants to plan an interim vote for exposure after the issue paper is updated for today’s actions or wait until a later date to consider for exposure. Mr. Bruggeman noted that the issue paper will be updated for the Working Group’s and the Task Force’s final actions, and it will be considered for exposure at a later date.

5. Considered Maintenance Agenda – Pending Listing – Exposures

Mr. Kim Hudson made a motion, seconded by Mr. Kasinow, to move agenda items 2021-01 through 2021-09, all of which are classified as nonsubstantive, to the active listing and expose all items for a public comment period ending April 30. The motion passed unanimously.

a. Agenda Item 2021-01

Mr. Bruggeman directed the Working Group to agenda item 2021-01: ASU 2021-01, Reference Rate Reform. Mr. Pinegar stated that in March 2020, the FASB issued ASU 2020-04 – Reference Rate Reform (Topic 848): Facilitation of the Effects of Reference Rate Reform on Financial Reporting. He stated that the Working Group adopted ASU 2020-04 in its entirety, where applicable, through its adoption of INT 20-01: ASU 2020-04 – Reference Rate Reform. ASU 2020-04 and INT 20-01 provided temporary, optional and expedient relief in that a qualifying contract modification (because of reference rate reform) should not be considered an event that requires contract remeasurement. This exception guidance applies to both general business and derivative contracts. Mr. Pinegar stated that since the issuance of ASU 2020-04, questions have arisen regarding the accounting for changes in reference rates (that do not specifically reference the London Interbank Offered Rate (LIBOR) or another rate that is expected to be discontinued) that are specifically used for margining, discounting, or contract price alignment. He stated that these items are generally referred to as “basis swaps,” and basis swaps were specifically addressed by the Working Group through INT 20-09: Basis Swaps as a Result of the LIBOR Transition. He stated that INT 20-09 requires basis swaps to be reported as “hedging other,” and they are recorded at fair value, unless the entity can prove hedge effectiveness, as is required per SSAP No. 86. However, ASU 2021-01 directs that basis swaps and other derivative instruments affected by changes to the interest rates used for discounting, margining, or contract price alignment (regardless of whether they reference LIBOR or another rate that is expected to be discontinued as a result of reference rate reform) are eligible for the optional relief provided for in ASU 2020-04. Mr. Pinegar stated that NAIC staff recommend minor modifications to INT 20-01 to reflect the additional financial instruments affected by ASU 2021-01.

b. Agenda Item 2021-02

Mr. Bruggeman directed the Working Group to agenda item 2021-02: ASU 2020-08 – Premium Amortization on Callable Debt Securities. Mr. Pinegar stated that ASU 2020-08 clarifies the amortization of premium associated with callable debt securities, and while the guidance closely mimics existing guidance in SSAP No. 26R, it does preclude the statutory accounting’s yield-to-worst concept. Accordingly, there may be scenarios for statutory accounting where application of the yield-to-worst concept will result in a lower asset value than amortizing callable debt premium in accordance with ASU 2020-08. Mr. Pinegar stated that this agenda item proposes to reject ASU 2020-08 in SSAP No. 26R.

c. Agenda Item 2021-03

Mr. Bruggeman directed the Working Group to agenda item 2021-03: SSAP No. 103R – Disclosures. Mr. Pinegar stated that this agenda item was drafted as a result of ongoing discussions with industry and state insurance regulators regarding the current
SSAP No. 43R project. One of the topics discussed was the state insurance regulators’ desire to identify situations in which a reporting entity has entered into a securitization, asset-backed financing, or similar transfer transaction where a significant economic interest in the transferred asset is retained by the reporting entity. Mr. Pinegar stated that one of the primary concerns is where an asset has been self-securitized, but the economic benefits have been retained. This agenda item proposes additional disclosures and data capturing certain existing disclosures required in SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities. Data capturing of these disclosure elements will permit state insurance regulators to have the ability to perform system inquiries to identify which reporting entities have such transactions and the extent to which they occur. This agenda item proposes a concurrent blanks exposure for possible inclusion in the 2021 year-end financial statements.

d. Agenda Item 2021-04

Mr. Bruggeman directed the Working Group to agenda item 2021-04: SSAP No. 97 – Valuation of Foreign Insurance SCAs. Fatima Sediqzad (NAIC) stated that this agenda item is in response to the Working Group’s previously adopted guidance in SSAP No. 97, indicating that equity method losses stop at zero (preventing a negative equity value) except in scenarios in which limited statutory adjustments result in a negative asset value. She noted that interested parties have requested that the Working Group consider an agenda item to reevaluate whether the ability to go negative from the limited statutory basis of accounting adjustments should remain applicable for SSAP No. 97, paragraph 8.b.iv (foreign insurance SCA) entities. She stated that these long-standing adjustments have historically been viewed as necessary in order to prevent non-admitted assets held by an SCA from receiving more favorable treatment than had the assets been held directly by the reporting entity. She stated that after a review of foreign SCA filings, there were no noted instances of negative value SCAs; therefore, revisions to SSAP No. 97 are not recommended. She stated that this agenda item is proposed to be disposed of without edits to statutory accounting.

Mr. Bruggeman stated that while this agenda item was brought forth as a theoretical exercise, industry is requested to demonstrate examples, specifically those that may not be subject to SCA filing requirements and, as a result, were not a part of the review performed by NAIC staff.

Angelica Tamayo-Sanchez (New York Life) stated that only reviewing foreign insurance SCAs that are subject to SSAP No. 97 filing requirements may not be representative of all foreign insurance SCAs captured in scope of SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies. Additionally, while negative valuation has not been an issue to date, requiring a potential negative equity valuation of a solvent foreign insurance subsidiary does not seem appropriate. Ms. Tamayo-Sanchez stated that a foreign insurance subsidiary should be treated in a similar manner as a domestic insurance subsidiary. Mr. Bruggeman requested that additional details and comments to be submitted during the exposure period.

e. Agenda Item 2021-05

Mr. Bruggeman directed the Working Group to agenda item 2021-05: Cryptocurrencies. Mr. Stultz stated that this agenda item has been drafted in response to inquiries received on the statutory accounting treatment for cryptocurrencies, specifically whether Bitcoin is an admitted asset and within the definition of SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments. This agenda item proposes INT 21-01T: Accounting for Cryptocurrencies to clarify that cryptocurrencies do not meet the definition of cash in SSAP No. 2R or any other admitted asset that is included in the AP&P Manual. Mr. Stultz stated that the exposure also requests information on the current ownership and potential future acquisition of cryptocurrencies.

f. Agenda Item 2021-06EP

Mr. Bruggeman directed the Working Group to agenda item 2021-06EP: Editorial Maintenance Update. Mr. Stultz stated that this agenda item provides nonsubstantive editorial corrections in accordance with the maintenance process. The revisions propose a minor update to the title of SSAP No. 53—Property Casualty Contracts—Premiums, correct grammatical errors in SSAP No. 97, and relocate an existing footnote in the Glossary.

g. Agenda Item 2021-07

Mr. Bruggeman directed the Working Group to agenda item 2021-07: ASU 2020-11, Financial Services—Insurance (Topic 944): Effective Date and Early Application. Mr. Stultz stated that ASU 2020-11 updates effective dates of the amendments in ASU 2019-09, Financial Services – Insurance and ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts.
Contracts. However, both ASU 2019-09 and ASU 2018-12 have previously been rejected for statutory accounting. He noted that the proposed nonsubstantive revisions to Appendix D reject ASU 2020-11 as not applicable to statutory accounting.

h. Agenda Item 2021-08

Mr. Bruggeman directed the Working Group to agenda item 2021-08: ASU 2021-02, Franchisors Revenue from Contracts with Customers. Mr. Stultz stated that ASU 2021-08 slightly amends the guidance that was previously issued in ASU 2014-09, Revenue from Contracts with Customers as it relates to franchisors. The Working Group has previously rejected ASU 2014-09 and several other ASUs related to revenue recognition in SSAP No. 47—Uninsured Plans. He noted that the nonsubstantive revisions propose to reject ASU 2021-02 in SSAP No. 47.

i. Agenda Item 2021-09: State ACA Reinsurance Programs

Mr. Bruggeman directed the Working Group to agenda item 2021-09: State ACA Reinsurance Programs. Ms. Marcotte stated that SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act provides guidance regarding the three federal Affordable Care Act (ACA) risk-sharing programs that had the intent to stabilize insurance rates in the marketplace. She stated that although the risk corridors program and the federal transitional reinsurance program have ended, several states have received approval from the U.S. Department of Health and Human Services (HHS) to run state ACA reinsurance programs under “Section 1332” waivers, which are similar to the federal transitional reinsurance program. This agenda item proposes nonsubstantive revisions to SSAP No. 107 to direct a hybrid accounting approach for the state ACA programs, which is similar to the federal transition reinsurance program. The hybrid accounting approach will divide the accounting into three broad categories, and depending on the characteristics of the plan, a reporting entity will account for the program per SSAP No. 63—Underwriting Pools, SSAP No. 35R—Guaranty Fund and Other Assessments, or SSAP No. 47.

6. Discussed Other Matters

a. Agenda Item 2020-21: SSAP No. 43R – Update

Ms. Gann stated that since December 2020, Iowa state insurance regulators, NAIC staff, and a small subset of interested parties have been meeting weekly to discuss the exposed Iowa Insurance Proposal to define what should be captured in scope of Schedule D, Part 1: Long-Term Bonds. The decision to review investments eligible for Schedule D, Part 1 reporting was determined an appropriate first step, as this schedule entails investments in scope of both SSAP No. 26R and SSAP No. 43R. Significant progress has been made during these meetings, and it is anticipated that an initial exposure will occur in May 2021, potentially to allow comments prior to the Summer National Meeting. Ms. Gann stated that the initial focus has been on principal concepts to differentiate between issuer credit obligations and asset-backed securities. It is anticipated that there will be investments that have been previously reported on Schedule D, Part 1 that will no longer qualify for bond reporting. At this time, it is anticipated that these investments will be captured on Schedule BA as an other long-term invested asset. However, despite potential Schedule BA reporting, consideration will be given to the proper accounting for these investments, and referrals to the Capital Adequacy (E) Task Force will occur to ensure appropriate consideration for RBC charges.

Mr. Clark stated that while this topic remains complex, all parties have approached the discussions in good faith, and as a result, significant progress has been made. He stated that the concern of state insurance regulators is investments that have been legally structured as a bond but do not reflect the characteristics of a bond that state insurance regulators would anticipate for Schedule D, Part 1 reporting. This structuring could result in a more favorable RBC charge than had the assets been held directly. Mr. Clark stated that the discussions with NAIC staff and the subset of interested parties remain principles-based and are anticipated for initial exposure in the near future.

Mr. Monahan, on behalf of the ACLI and interested parties, stated appreciation for the Iowa state insurance regulators, NAIC staff, and interested parties for assisting with the ongoing SSAP No. 43R project. Mr. Bruggeman stated that remaining principles-based is an important aspect of the project, and he noted that beginning with the review of Schedule D, Part 1 was appropriate, as its implications may affect investments captured in both SSAP No. 26R and SSAP No. 43R.

b. INT 19-02: Freddie Mac Single Security Initiative

Ms. Gann stated that INT 19-02 remains applicable as long as securities are exchanged under the Freddie Mac Single Security Initiative. She stated that NAIC staff researched this item, and as the Freddie Mac Single Security Initiative remains an ongoing
program, INT 19-02 remains in full effect. Subsequent reviews will continue to assess continued applicability.

c. **Agenda Item 2019-49: Retroactive Reinsurance Exception – Update**

Ms. Marcotte stated that this agenda item was to address a referral from the Committee on Property and Liability Financial Reporting (COPLFR) of the American Academy of Actuaries (Academy) that noted diversity in reporting for companies applying the retroactive reinsurance exception by allowing certain contracts to be reported prospectively. She stated that NAIC staff have held some preliminary discussion with members of the Casualty Actuarial and Statistical (C) Task Force on this topic, and they anticipate additional discussions with industry. A proposal is anticipated for Working Group review for exposure either in the interim or at the Summer National Meeting.

d. **Paycheck Protection Program (PPP) – SAP Guidance**

Ms. Marcotte stated that in response to questions received, statutory accounting guidance for the forgiveness of Paycheck Protection Program (PPP) loans is addressed in SSAP No. 15—Debt and Holding Company Obligations, paragraph 11, and it provides that debt is recognized until extinguished, including formally being forgiven. In addition, per SSAP No. 15, paragraph 25, gains on termination of debt are recognized as capital gains.

e. **VOSTF Referral Regarding WCFI**

Ms. Marcotte stated that a referral from the Valuation of Securities (E) Task Force regarding revisions to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) in response to the Working Group’s May 2020 revisions to SSAP No. 105R—Working Capital Finance Investments is expected. NAIC staff anticipate addressing this referral when received.

f. **Review of GAAP Exposures:**

Ms. Sediqzad stated that NAIC staff have reviewed the outstanding U.S. GAAP exposure, and she noted that comments during the exposure period are not recommended; however, a review will occur once the new ASU is issued as final.

Mr. Bruggeman stated that the comment deadline for all exposed agenda items is April 30.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded Jan. 25, 2021. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Vice Chair (IA); Richard Ford (AL); Kim Hudson (CA); William Arfanis (CT); Eric Moser (IL); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); David Smith (VA); and Amy Malm (WI).

1. **Extended INT 20-03 and INT 20-07**

As directed by the Working Group during its Jan. 6 e-vote, as public comments (Attachments One-A1 and One-A2) were supportive of extending two previously adopted interpretations (INTs), the Working Group conducted an e-vote to consider extension of **INT 20-03: Troubled Debt Restructuring Due to COVID-19** and **INT 20-07: Troubled Debt Restructuring for Certain Debt Instruments Due to COVID-19**. A summary of the INTs is as follows:

1) **INT 20-03** – This INT clarifies that a modification of mortgage loan or bank loan terms in response to COVID-19 shall follow the provisions detailed in the April 7, 2020, “Interagency Statement on Loan Modifications and Reporting for Financial Institutions Working with Customers Affected by the Coronavirus” and the provisions of the federal Coronavirus Aid, Relief and Economic Security (CARES) Act in determining whether the modification shall be reported as a troubled debt restructuring. This INT had an effective date that mirrored the original CARES Act, and it originally terminated on Dec. 31, 2020. As extended, the INT is now applicable through whichever date is earlier—Jan. 1, 2022, or the date that is 60 days after the date on which the national emergency concerning the COVID-19 outbreak terminates.

2) **INT 20-07** – This INT provides temporary practical expedients in assessing whether modifications in response to COVID-19 are insignificant under **Statement of Statutory Accounting Principles (SSAP) No. 36—Troubled Debt Restructuring** and whether a modification shall be considered an exchange under **SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities**. This INT had an effective date that mirrored the original CARES Act, and it originally terminated on Dec. 31, 2020. As extended, the INT is now applicable through whichever date is earlier—Jan. 1, 2022, or the date that is 60 days after the date on which the national emergency concerning the COVID-19 outbreak terminates.

Mr. Guerin made a motion, seconded by Mr. Smith, to extend INT 20-03 (Attachment One-A3) and INT 20-07 (Attachment One-A4). The motion passed unanimously.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
January 22, 2021

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Items Exposed for Comment by the Statutory Accounting Principles Working Group on November 12, 2020 with Comments due January 22, 2021

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the exposure drafts released for comment by the NAIC Statutory Accounting Principles (E) Working Group (the Working Group). We offer the following comments:

INT 20-03: Troubled Debt Restructuring Due to COVID-19

This interpretation was effective for the specific purpose to address loan modifications in response to COVID-19. Consistent with the CARES act, this interpretation was only applicable for the term of the loan modification, but solely with respect to any modification, including a forbearance arrangement, interest rate modification, a repayment plan and other similar arrangement that defer or delays the payment of principal or interest for a loan that was not more than 30 days past due as of December 31, 2019. As determined in the CARES Act, this interpretation was originally only applicable for the period beginning on March 1, 2020 and ending on the earlier of December 31, 2020, or the date that was 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID-19) outbreak declared by the President on March 13, 2020 under the National Emergencies Act (50 U.S.C. 1601 et seq.) terminates.

On December 27, 2020, President Trump signed into law the Consolidated Appropriations Act, 2021, which slightly modified and extended the original CARES Act. These modifications included extending the provisions for temporary relief from troubled debt restructurings. Accordingly, on January 6, 2021, the provisions in this INT were tentatively extended to be applicable through the earlier of January 1, 2022 or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID-19), outbreak declared by the President on March 13, 2020 under the National Emergencies Act terminates. With this extension, this INT’s effective date corresponds with the current effective dates of the CARES Act. Unless the outbreak under the National Emergencies Act terminates, this INT will automatically expire on January 2, 2022 (to include year-end 2021 financial statements reporting).

Interested parties support the continued consistency with the Cares Act.
INT 20-07: Troubled Debt Restructuring of Certain Debt Investments Due to COVID-19

This interpretation was originally effective for the specific purpose to provide practical expedients in assessing whether modifications in response to COVID-19 are insignificant under SSAP No. 36 and in assessing whether a change is substantive under SSAP No. 103R. This interpretation will only be applicable for the period beginning on March 1, 2020 and ending on the earlier of December 31, 2020, or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID–19) outbreak declared by the President on March 13, 2020 under the National Emergencies Act (50 U.S.C. 1601 et seq.) terminates. For clarity, this effective timeframe specifies when modifications in response to COVID-19 can be incorporated using the provisions of this interpretation. Once incorporated, the provisions of this interpretation will continue for the duration of the modification.

On December 27, 2020, President Trump signed into law the Consolidated Appropriations Act, 2021, which slightly modified and extended the original CARES Act. These modifications included extending the provisions for temporary relief from troubled debt restructurings. Accordingly, on January 6, 2021, the provisions in this INT were tentatively extended to be applicable through the earlier of January 1, 2022 or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID–19), outbreak declared by the President on March 13, 2020 under the National Emergencies Act terminates. With this extension, this INT’s effective date corresponds with the current effective dates of the CARES Act. Unless the outbreak under the National Emergencies Act terminates, this INT will automatically expire on January 2, 2022 (to include year-end 2021 financial statements reporting).

Interested parties support the continued consistency with the Cares Act.

Ref #2019-24: Levelized and Persistency Commission

On November 12, 2020, the Working Group held a hearing to receive comments and based on those comments, took the following actions:

- Re-exposed the prior version of SSAP #71 with certain edits: – (1) the proposed effective date of Jan.1, 2021 was changed to be effective upon adoption, and (2) the revised text made explicit that the proposed revisions will apply to contracts in effect as of the date of adoption.

- Determined that the revisions to SSAP #71 met the due process for either a substantive or a non-substantive revision but concluded to keep the revision classified as nonsubstantive. The Working Group reiterated that it is not the impact of a change on an individual entity that determines whether a change is substantive or non-substantive, but whether the revision is in line with the original intent of the SSAP. The Working group noted that this is a clarification of existing guidance consistent with original intent. (Commissioner Donelon noted an objection to the classification as non-substantive.)

- Directed NAIC Staff to draft an Issue Paper to document the discussion on this topic for historical purposes.
Interested parties would like to again thank the Working Group for the opportunity to continue to comment on the most recent revisions to exposure Ref #2019-24 – Levelized and Persistency Commission (SSAP No. 71, Policy Acquisition Costs and Commissions) discussed on November 12, 2020 (the “Exposure”).

These comments begin with industry comments regarding the Working Group’s most recent revisions to the Exposure:

**Paragraph #5 new comments pertain to the sentence below:**

Having a third party pay commission costs to the selling agent is strong evidence of a potential funding arrangement which shall be recognized as a liability because the substance of the arrangement indicates that repayment is reasonable and probable, even if a contingency has been incorporated into the funding arrangement, until the underlying policy has been cancelled.

The Working Group has made a change to the last phrase of this sentence that still does not provide clarity as to its meaning and to the sentence as a whole. Assuming that the phrase refers to the contingency noted in the previous phrase within the sentence, industry disagrees with wording that creates a blanket statement across all third-party agreements with regard to recognizing a liability similar to a funding agreement. During the entire exposure/revision process, interested parties has consistently stated that agreements which include traditional elements such as persistency as part of a legally binding commission contract should be excluded from the funding agreement treatment as was provided in the original (current) SSAP No. 71 wording. If the last phrase “until the underlying policy has been cancelled” pertains to the recognition of the liability, it seems that the wording does not contemplate even a partial repayment of the liability during the period when the policy is active.

**Paragraph #7 new comments pertain to the following:**

The nonsubstantive revisions adopted TBD date regarding levelized commission are to clarify the original intent of this statement and apply to existing contracts are effective in effect on the date of adoption of the revisions January 1, 2021.

Industry has consistently maintained that there has been a long-standing industry practice to link third party contracts to insurance elements such as persistency, including commission arrangements, reinsurance contracts, etc. Removing this link as has been indicated in the Working Group revisions is a substantive change. As such, we do not agree with the language in paragraph #7 that calls the revisions nonsubstantive and we disagree that such changes should be put in effect immediately upon adoption since they are substantive in nature and require further evaluation.

Certain of the third-party contracts noted above are complex and not quite as simple as the description of levelized commissions in the most recent draft of the Exposure. The Exposure depicts a simple arrangement whereby the insurer repays a third party over time, with interest, for making upfront heaped commissions to agents. This does not consider, for example, certain third-party contracts for which the insurer pays the third-party trail commissions based upon account value in-force in exchange for performing many contractual agency services other than simply funding and making upfront payments to selling agents. Such complex contracts require sufficient time to allow insurers to work with their state of domicile to determine the correct application of the revised guidance with respect to contracts which the regulator has already approved. Then, if establishment of a liability is indeed required,
additional time would be necessary to calculate such an accrual and review with external auditors prior to reporting the change on a quarterly or annual statement. For these reasons, and as you suggested, Chairman Bruggeman, we propose that the revisions within the Exposure be adopted with an effective date no sooner than 12/31/21.

Comments previously made on existing revisions included for purposes of documentation:

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

Paragraph #4, most recent exposure with highlighted edits:
4. Levelized commissions occur in situations where agents receive normal (non-level) commissions with payments made by a third party. It is intended, but not necessarily guaranteed, that the amounts paid to the agents by the third party would ultimately be repaid (with interest explicit or implied) to the third party by levelized payments (which are less than the normal first year commissions but exceed the normal renewal commissions) from the reporting entity over time. (Note: levelized repayments made by the reporting entity extend the repayment period but might not be a straight-line repayment.) In instances where the levelized commission is not tied to, or contingent upon, traditional elements such as policy persistency or premium payments, these transactions are, in fact, funding agreements between a reporting entity and a third party, regardless of how the payment to the third party is characterized when the contract between the reporting entity and the third party has no substance but to defer commission payments by the reporting entity. The continuance of the stream of payments specified in the levelized commission contract in these situations is a mechanism which attempts to bypass recognition of those expenses which are ordinarily charged to expense in the first year of the contract. Consequently, the normal link between the persistency of the policy, the continuance of the premium payment or the maintenance of the agent's license with the reporting entity is not maintained with respect to the payment stream.

Industry proposes to replace a large section of paragraph #5, including the Working Group recent revisions, with more concise language that expresses the need to establish a liability when an arrangement is in substance a funding agreement. The current revisions are lengthy and somewhat redundant. Industry continues to disagree with the current revisions which too broadly state that all third-party arrangements, even those with traditional insurance elements, are considered funding arrangements. Industry retained the concept of the link between the accrual of commissions and traditional elements such as policy persistency.
Excerpt from paragraph #5, most recent exposure requested to be deleted:
Arrangements that use a third party to pay agents who write policies for the reporting entity and the insured can be an attempt to de-link the relationship between the insurer and those agents and defer or levelize the acquisition commissions. The insurance reporting entity is required to recognize the full amount of earned commission costs to the direct policy writing agents even if those costs are paid indirectly to the agents by a third party through the use of levelized commission, or similar arrangement, which is in substance a funding arrangement. Having a third party pay commission costs to the selling agent is strong evidence of a potential funding arrangement which shall be recognized as a liability because the substance of the arrangement indicates that repayment is reasonable and probable, even if a contingency has been incorporated into the funding arrangement, until the underlying policy has been cancelled. A third-party structure cannot recharacterize (e.g. by referencing policy persistency) and delay recognition of liabilities for initial sales commission owed from the writing of policies regardless of how a third-party arrangement is structured with regards to the timing of payment from the insurer. The amount owed for full initial sales commission shall be recognized immediately as the writing of an insurance contract is the event that obligates the insurer, and such action shall occur consistently among insurers. As such, this recognition is required regardless if the insurer owes a selling agent directly or if a third-party has been contracted to provide payment to the selling agent.

Interested parties highlighted wording to replace the above excerpt from paragraph #5:
The reporting entity is required to recognize the full repayment amount of earned commission costs by the direct policy writing agents even if those costs are paid indirectly by a third party through the use of levelized commission, or similar arrangement, which is in substance a funding arrangement. Recognition of those commission costs and recording a liability is required in such arrangements that are not linked to or contingent upon traditional elements. Such treatment shall occur consistently among insurers.

Summary:
Since its initial exposure in August 2019, industry has had concerns with the substantive nature of the proposed revisions and has consistently expressed these concerns.

- The last paragraph of the current SSAP No. 71 states: “The use of an arrangement where commission payments are not linked to traditional elements such as premium payments and policy persistency, but rather are linked to the repayment of an advance amount requires the establishment of a liability for the full amount of the unpaid principal and accrued interest which is payable to a third party related to levelized commissions.” This wording was revised to instead explicitly include arrangements linked to traditional elements with those that have no substance other than to link to the repayment of an advance amount. This is clearly a substantive change and not clarifying the original intent. It is a change to the intent.

- The current revisions require the accrual of a liability in situations that are inconsistent with the guidance SSAP No. 5R. Under a levelized commission program a third party has the obligation for the full initial sales commission. The insurer’s obligation under a levelized commission program that incorporates persistency should be accrued to the extent of legally contracted amounts owed. We do not believe the original intent of the SSAP required accruing for amounts
that are not yet due and that may never be due. We strongly feel that the recognition of an obligation based on persistency is in accordance with the principles of SSAP 5R.

- The interpretation of SSAP No. 71 that persistency is the obligating event for accrual of the levelized/persistency commissions is long-standing industry practice that has been subject to both independent audits and state insurance department examinations without this interpretation being raised as an issue nor requiring adjustments to the companies’ financial statements.

- The current proposed language does not address the many varying product/distribution compensation arrangements in the industry and interested parties continue to believe this will cause unintended consequences.

- The existing SSAP No. 71 guidance is consistent in the application of persistency being part of the transfer of the risk (liability) to another party. If the lapse risk (persistency) is transferred to another party, the liability that the insurance company may have is also transferred to that party and the insurance company has no liability. Removing persistency as a factor in the accrual of commissions is a dangerous precedent. The differentiation between commissions based on real insurance risks versus payments based solely upon the passage of time in SSAP No. 71 goes directly to the risk transfer issue of one type of level commissions versus another. The proposed additional language eliminates this differentiation.

**Conclusion:**

Industry continues to maintain that the revisions exposed have changed the original intent of SSAP No. 71 and do not believe that they are nonsubstantive. Removing insurance elements from the determination of obligating events of third-party commission contracts may set a precedent that will have significant unintended consequences. As such, interested parties request that the Working Group consider these comments and proposed revisions. In addition, we request that this exposure be categorized as substantive, and given due process and an effective date.

**Ref #2019-34: Related Parties, Disclaimers of Affiliation and Variable Interest Entities**

The Working Group exposed this agenda item, with detailed revisions to SSAP No. 25, as detailed in a draft labeled with the date of November 12, 2020.

That draft contained proposed revisions intended to address the following key aspects:

- Clarify the identification of related parties and ensure that any related party identified under U.S. GAAP or SEC reporting requirements would be considered a related party under statutory accounting principles.

- Clarify that non-controlling ownership over 10% results in a related party classification regardless of any disclaimer of control or disclaimer of affiliation.
Clarify the impact of a disclaimer of control or disclaimer of affiliate under SAP. As detailed, such disclaimers impact holding company group allocation and reporting as an SCA under SSAP No. 97, but do not eliminate the classification as a “related party” and the disclosure of material transactions as required under SSAP No. 25.

Proposes rejection of several U.S. GAAP standards addressing variable interest entities.

On December 10, 2020, some members of interested parties and NAIC staff had a conference call to discuss the November 12th draft and possible edits to address concerns that the draft unintentionally impacted passive investments held by insurers in addition to investment in insurers. Staff amended the draft to address these concerns and is taking the updated draft back to the Working Group for its consideration.

Interested parties thank the staff for meeting with industry and in working to address our concerns.

Ref #2020-22: Accounting for Perpetual Bonds

The Working Group exposed revisions to SSAP No. 26R—Bonds to clarify that perpetual bonds are within scope as a “bond,” and shall apply the yield-to-worst concept. Additionally, perpetual bonds that do not possess or no longer possess a call feature shall follow fair value reporting.

Interested parties appreciated the opportunity to work directly with NAIC staff on this topic. After reviewing the modified proposal, we have one remaining comment, which has already been discussed with NAIC Staff. In paragraph 9, the proposal reads as follows:

“New Footnote: For perpetual bonds with an effective call option, any applicable premium shall be amortized to the next effective call date. For perpetual bonds purchased at a discount, any applicable discount shall be accreted utilizing the yield-to-worst concept.”

We recommend the language be “fine-tuned” as it implies those with a remaining premium would be amortized to the next effective call date. The language regarding amortization should be aligned with other bonds and reference the use of the yield to worst method, not the next effective call date. We suggest the following wording:

“New footnote: For perpetual bonds with an effective call option, any applicable premium shall be amortized utilizing the yield-to-worst method.”

Ref #2020-32: SSAP No. 26R - Disclosure Update

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 26R—Bonds to expand the called bond disclosures to also include bonds terminated early through a tender offer.

Interested parties have no comments on this item.
**Ref #2020-33: SSAP No. 32R – Publicly Traded Preferred Stock Warrants**

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 32R—Preferred Stock and SSAP No. 86—Derivatives to scope publicly traded preferred stock warrants into SSAP No. 32R with accounting at fair value.

Interested parties have no comments on this item.

**Ref #2020-34: SSAP No. 43R – Government-Sponsored Enterprises – Credit Risk Transfer Transactions**

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 43R—Loan-Backed and Structures Securities to incorporate minor scope modifications to reflect recent changes to the STACR and CAS programs. The proposed edits would allow credit risk transfer securities from Freddie Mac and Fannie Mae to remain in scope of SSAP No. 43R when a REMIC structure is used in the STACR program or CAS program.

Interested parties have no comments on this item.

**Ref #2020-35: SSAP No. 97 – Audit Opinions**

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed this agenda item with a request for comments on the extent in which situations exist that hinder admittance of 8.b.iii. entities due to the inability to quantify a departure from U.S. GAAP.

Interested parties is not aware of any situations that hinder admittance of 8.b.iii entities due to the departure of U.S. GAAP as a result of the inability to quantify the departure.

**Ref #2020-37: Separate Account – Product Identifiers**

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed the agenda item to solicit comments from state insurance regulators and industry regarding the degree of product identifying details needed to adequately assess the product features and reserve liabilities in the separate account. Particularly, this is requesting feedback on how to obtain increased product identifier reporting granularity in question 1.01 (product mix) of the separate account general interrogatories (GI 1.01). Additionally, feedback is requested regarding if a threshold should be established for when aggregate reporting would be permitted.

In response to the solicitation of feedback on additional product identifiers specifically for PRT and RILA transactions in the Separate Account General Interrogatories, the ACLI suggests adding a PRT and RILA product identifier. See example identifiers in bold:
The addition of these identifiers would bifurcate out PRT and RILA transactions. Further, the use of these additional identifiers would show in General Interrogatory 1.01 if there were guarantees associated with these different products.

**Ref #2020-38: Pension Risk Transfer – Separate Account Disclosure**

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed the agenda item to solicit comments from state insurance regulators and industry regarding possible modifications to SSAP No. 56—Separate Accounts specific to pension risk transfer (PRT) products. Depending upon the feedback received, the Working Group would have several options available including, but not limited to, requiring the separate identification of pension risk transfer products (including transactions, guarantees, reserve assumptions, etc.) within existing disclosure requirements or the addition of a new general interrogatory (and perhaps new separate accounting reporting schedules / exhibits) to separate specific product detail that was previously reported in an aggregated format.

Pension risk transfer transactions differ from other separate account transactions in that PRT products are group products, not individual products. The American Council of Life Insurers believes that these differences are adequately addressed in the current disclosure requirements of SSAP No. 56 – Separate Accounts. Specifically, paragraphs 31c and 33a include disclosure requirements for products with guarantees, which may include PRT transactions. Further, these disclosure requirements extend to the General Account Annual Statement Note 35B. Additionally, the proposal above on Ref# 2020-37 will provide additional detail for PRT products in the General Interrogatories.

We believe that the current disclosures sufficiently capture PRT transactions however, we defer to the Working Group and regulators if these groups voice concern that they are not able to discern something specific.
Ref #2020-39: Interpretation Policy Statement Updates

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to *NAIC Policy Statement on Maintenance of Statutory Accounting Principles* in Appendix F—*Policy Statements* regarding the issuance and adoption of accounting interpretations.

Based upon interested parties’ discussion with NAIC staff and our understanding of the objective of the changes to *NAIC Policy Statement on Maintenance of Statutory Accounting Principles* in Appendix F—*Policy Statements* (Appendix F), we’ve marked up Appendix F with edits that clarify the policy for issuing interpretations which amend, supersede, or conflict with existing SSAPs (please see attached). Specifically, the interested parties’ proposed revisions clarify that such interpretations are temporary and restricted to circumstances requiring immediate, temporary guidance such as catastrophes or other emergencies. We believe the marked Appendix F is consistent with the intent to use interpretations in limited circumstances. Our proposed revisions explicitly establish that interpretations are not intended as a shortcut to bypass the deliberative process for amending existing statutory accounting guidance or developing new guidance.

Ref #2020-40: Clarification of Prescribed Practices

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed proposed revisions to the Preamble Implementation Questions and Answers to clarify prescribed practices. These revisions clarify that while any state in which a company is licensed can issue prescribed practices, the prescribed practices directed by the domiciliary state shall be reflected in the financial statements filed with the NAIC and are the financial statements subject to the independent audit requirements.

Interested parties are concerned that the discussion of prescribed and permitted practices in this proposal are likely to cause confusion. An insurer’s annual and quarterly statutory statements that are filed with the state of domicile and all states the insurer is licensed are prepared in accordance with the accounting practices prescribed or permitted by the state of domicile. However, in addition to the financial statements required by the domiciliary state, a non-domiciliary state in which the company is licensed may require an insurer to file supplemental financial information that require or allow the use of different accounting practices in the supplementary filing than provided in the AP&P manual. We believe the proposal should be amended to clarify that if a non-domiciliary state in which the company is licensed requires or allows a practice by state statute / bulletin (or other state-wide provision) in such supplemental financial information that is different from NAIC SAP, that practice(s) is also considered a prescribed practice. We recommend changes to the proposed wording to clarify these points (please see attached).

Ref #2020-41: ASU 2020-06 - Convertible Instruments

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets, SSAP No. 72—Surplus and Quasi-Reorganizations and SSAP No. 86—Derivatives, to reject ASU 2020-06, Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity’s
Own Equity (Subtopic 815-40), Accounting for Convertible Instruments and Contracts in an Entity’s Own Equity for statutory accounting.

Interested parties have no comment on this item.

Ref #2020-42: ASU 2020-07 - Presentation and Disclosures by Not-for-Profit Entities

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2020-07, Not-for-Profit Entities (Topic 958), Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets as not applicable to statutory accounting.

Interested parties have no comment on this item.

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Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell     Rose Albrizio

cc: NAIC staff
    Interested parties

w://national.meetings/2021/spring/tf/app/sap/minutes/att a1_dkb2339.docx
January 15, 2021

Mr. Dale Bruggeman
Chair, Statutory Accounting Principles (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: Working Group’s Recent Action on INT 20-03 and INT 20-07

Dear Mr. Bruggeman:

The Mortgage Bankers Associations (MBA)\(^1\) and the American Council of Life Insurers (ACLI),\(^2\) on behalf of our respective member insurers, express their support for the Statutory Accounting Principles (E) Working Group’s proposed extensions of the periods covered by INT 20-03 and INT 20-07, to conform them to the period covered by section 4013 of the CARES Act, *Temporary Relief from Troubled Debt Restructurings (TDR)*, as amended on December 27, 2020.

We believe it is appropriate for SAPWG to continue to harmonize insurers’ financial reporting of modifications of mortgage loans and certain other debt instruments under statutory accounting standards and financial reporting of the same modifications under United States Generally Accepted Accounting Principles (US GAAP).

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\(^1\) The Mortgage Bankers Association (MBA) is the national association representing the real estate finance industry, an industry that employs more than 280,000 people in virtually every community in the country. Its membership of over 2,300 companies includes all elements of real estate finance: mortgage companies, mortgage brokers, commercial banks, credit unions, thrifts, REITs, Wall Street conduits, 70 life insurance companies engaged in real estate finance, and others in the mortgage lending field. For additional information, visit MBA’s website: www.mba.org

\(^2\) The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 95 percent of industry assets in the United States. Learn more at acli.com.
We want to take this opportunity to express on behalf our members our appreciation for how quickly and effective the SAPWG has operated throughout this pandemic to provide insurers with certainty as to these important accounting issues.

Sincerely,

Mike Flood                      Paul Graham

cc: Julie Gann, Assistant Director-Solvency Policy
    Robin Marcotte, Senior Manager, Accounting Policy
    Jim Pinegar, Manager II – Accounting Policy
    Fatima Sediqzad, Senior SCA Valuation & Accounting Policy Advisor
    Jake Stultz, Senior Accounting and Reinsurance Policy Advisor

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Interpretation of the Statutory Accounting Principles (E) Working Group

INT 20-03: Troubled Debt Restructuring Due to COVID-19

INT 20-03 Dates Discussed
March 26, 2020; April 15, 2020; January 6, 2021; January 25, 2021

INT 20-03 References
SSAP No. 36—Troubled Debt Restructuring

INT 20-03 Issue

1. A previously unknown virus began transmitting between October 2019 and March 2020, with the first deaths in the U.S. reported in early March 2020. The disease caused by the virus is known as Coronavirus Disease 2019 (COVID-19). Several states and cities have issued “stay home” orders and forced all non-essential businesses to temporarily close. This led to a significant increase in unemployment and the potential permanent closure of many businesses. Total economic damage is still being assessed however the total impact is likely to exceed $1 trillion in the U.S. alone.

2. In response to COVID-19, Congress and federal and state prudential banking regulators have considered provisions pertaining to mortgage loans as a result of the effects of the COVID-19. These provisions are intended to be applicable for the term of the loan modification, but solely with respect to a modification, including a forbearance arrangement, an interest rate modification, a repayment plan, and any other similar arrangement that defers or delays the payment of principal or interest, that occurs during the applicable period for a loan that was not more than 30 days past due as of December 31, 2019.

3. Furthermore, guidance has been issued by the Financial Condition (E) Committee to all U.S. insurers filing with the NAIC in an effort to encourage insurers to work with borrowers who are unable, or may become unable, to meet their contractual payment obligations because of the effects of COVID-19. As detailed in that guidance, the Committee, which is the NAIC parent committee of all the solvency policy making task forces and working groups of the NAIC, supports the use of prudent loan modifications that can mitigate the impact of COVID-19.

4. This interpretation considers the interagency guidance issued by federal and state prudential banking regulators on March 22, 2020, addressing whether the modification of mortgage loan or bank loan terms in response to COVID-19 shall be considered a troubled debt restructuring.

INT 20-03 Discussion

5. SSAP No. 36—Troubled Debt Restructuring provides guidance, predominantly adopted from U.S. GAAP, in determining whether a debt restructuring is considered a troubled debt restructuring. Additionally, SSAP No. 36 provides accounting and disclosure guidance when a troubled debt restructuring has been deemed to occur. Pursuant to existing guidance in SSAP No. 36, a debt restructuring is not necessarily considered a troubled debt restructuring and a creditor must assess whether the debtor is experiencing financial difficulties. The guidance also indicates that a delay in payment that is insignificant is not a concession.
6. On March 22, 2020, the federal and state prudential banking regulators issued a joint statement that included guidance on their approach to the accounting for loan modifications in light of the economic impact of the coronavirus pandemic. The guidance was developed in consultation with the staff of the FASB who concur with the approach and indicated that they stand ready to assist stakeholders with any questions. This interagency statement is provided below and is accessible through the FASB response via the following link:

https://fasb.org/cs/Satellite?c=FASBContent_C&cid=1176174374016&pagename=FASB%2FFASBContent_C%2FFNewsPage

Interagency Statement on Loan Modifications and Reporting for Financial Institutions Working with Customers Affected by the Coronavirus

The Board of Governors of the Federal Reserve System (FRB), the Federal Deposit Insurance Corporation (FDIC), the National Credit Union Administration (NCUA), the Office of the Comptroller of the Currency (OCC), the Consumer Financial Protection Bureau (CFPB), and the State Banking Regulators (hereafter, the agencies), are issuing this interagency statement to provide additional information to financial institutions who are working with borrowers affected by the Coronavirus Disease 2019 (also referred to as COVID-19). The United States has been operating under a presidentially declared emergency since March 13, 2020, and financial institutions and their customers are affected by COVID-19. The agencies understand that this unique and evolving situation could pose temporary business disruptions and challenges that affect banks, credit unions, businesses, borrowers, and the economy. The agencies will continue to communicate with the industry as this situation unfolds, including through additional statements, webinars, frequently asked questions, and other means, as appropriate.

Working with Customers

The agencies encourage financial institutions to work prudently with borrowers who are or may be unable to meet their contractual payment obligations because of the effects of COVID-19. The agencies view loan modification programs as positive actions that can mitigate adverse effects on borrowers due to COVID-19. The agencies will not criticize institutions for working with borrowers and will not direct supervised institutions to automatically categorize all COVID-19 related loan modifications as troubled debt restructurings (TDRs). The agencies will not criticize financial institutions that mitigate credit risk through prudent actions consistent with safe and sound practices. The agencies consider such proactive actions to be in the best interest of institutions, their borrowers, and the economy. This approach is consistent with the agencies’ longstanding practice of encouraging financial institutions to assist borrowers in times of natural disaster and other extreme events. The agencies also will not criticize institutions that work with borrowers as part of a risk mitigation strategy intended to improve an existing non-pass loan.

Accounting for Loan Modifications

Modifications of loan terms do not automatically result in TDRs. According to U.S. GAAP, a restructuring of a debt constitutes a TDR if the creditor, for economic or legal reasons related to the debtor’s financial difficulties, grants a concession to the debtor that it would not otherwise consider. The agencies have confirmed with staff of the Financial Accounting Standards Board (FASB) that short-term modifications made on a good faith basis in response to COVID-19 to borrowers who were current prior to any relief, are not TDRs. This includes short-term (e.g., six months) modifications such as payment deferrals, fee waivers, extensions of repayment terms, or other delays in payment that are insignificant. Borrowers considered current are those that are less than 30 days past due on their contractual payments at the time a modification program is implemented.
Working with borrowers that are current on existing loans, either individually or as part of a program for creditworthy borrowers who are experiencing short-term financial or operational problems as a result of COVID-19, generally would not be considered TDRs. For modification programs designed to provide temporary relief for current borrowers affected by COVID-19, financial institutions may presume that borrowers that are current on payments are not experiencing financial difficulties at the time of the modification for purposes of determining TDR status, and thus no further TDR analysis is required for each loan modification in the program.

Modification or deferral programs mandated by the federal or a state government related to COVID-19 would not be in the scope of ASC 310-40, e.g., a state program that requires all institutions within that state to suspend mortgage payments for a specified period.

The agencies’ examiners will exercise judgment in reviewing loan modifications, including TDRs, and will not automatically adversely risk rate credits that are affected by COVID-19, including those considered TDRs. Regardless of whether modifications result in loans that are considered TDRs or are adversely classified, agency examiners will not criticize prudent efforts to modify the terms on existing loans to affected customers.

In addition, the FRB, the FDIC, and the OCC note that efforts to work with borrowers of one-to-four family residential mortgages as described in the modification section of this document, where the loans are prudently underwritten, and not past due or carried in nonaccrual status, will not result in the loans being considered restructured or modified for the purposes of their respective risk-based capital rules.

Past Due Reporting

With regard to loans not otherwise reportable as past due, financial institutions are not expected to designate loans with deferrals granted due to COVID-19 as past due because of the deferral. A loan’s payment date is governed by the due date stipulated in the legal loan documents. If a financial institution agrees to a payment deferral, this may result in no contractual payments being past due, and these loans are not considered past due during the period of the deferral.

Nonaccrual Status and Charge-Offs

Each financial institution should refer to the applicable regulatory reporting instructions, as well as its internal accounting policies, to determine if loans to stressed borrowers should be reported as nonaccrual assets in regulatory reports. However, during the short-term arrangements discussed in this statement, these loans generally should not be reported as nonaccrual. As more information becomes available indicating a specific loan will not be repaid, institutions should refer to the charge-off guidance in the instructions for the Consolidated Reports of Condition and Income.

Discount Window Eligibility

Institutions are reminded that loans that have been restructured as described under this statement will continue to be eligible as collateral at the FRB’s discount window based on the usual criteria.

7. On March 27, 2020, President Donald Trump signed into law the Coronavirus Aid, Relief and Economic Security Act (CARES Act). The provisions in Section 4013 specifically address temporary relief from troubled debt restructurings. On December 27, 2020, President Trump signed into law the Consolidated Appropriations Act, 2021, which slightly modified and extended the original CARES Act as shown below:
SEC. 4013. TEMPORARY RELIEF FROM TROUBLED DEBT RESTRUCTURINGS.

(a) DEFINITIONS.—In this section:

(1) APPLICABLE PERIOD.—The term “applicable period” means the period beginning on March 1, 2020 and ending on the earlier of December 31, 2020 January 1, 2022 or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID–19) outbreak declared by the President on March 13, 2020 under the National Emergencies Act (50 U.S.C. 1601 et seq.) terminates.

(2) APPROPRIATE FEDERAL BANKING AGENCY.—The term “appropriate Federal banking agency”—
(A) has the meaning given the term in section 3 of the Federal Deposit Insurance Act (12 U.S.C. 1813); and
(B) includes the National Credit Union Administration.

(b) SUSPENSION.—

(1) IN GENERAL.—During the applicable period, a financial institution including an insurance company may elect to— (A) suspend the requirements under United States generally accepted accounting principles for loan modifications related to the coronavirus disease 2019 (COVID–19) pandemic that would otherwise be categorized as a troubled debt restructuring; and (B) suspend any determination of a loan modified as a result of the effects of the coronavirus disease 2019 (COVID–19) pandemic as being a troubled debt restructuring, including impairment for accounting purposes under United States Generally Accepted Accounting Principles.

(2) APPLICABILITY.—Any suspension under paragraph (1)—

(A) shall be applicable for the term of the loan modification, but solely with respect to any modification, including a forbearance arrangement, an interest rate modification, a repayment plan, and any other similar arrangement that defers or delays the payment of principal or interest, that occurs during the applicable period for a loan that was not more than 30 days past due as of December 31, 2019; and

(B) shall not apply to any adverse impact on the credit of a borrower that is not related to the coronavirus disease 2019 (COVID–19) pandemic.

(c) DEFERENCE.—The appropriate Federal banking agency of the financial institution including an insurance company shall defer to the determination of the financial institution, including an insurance company, to make a suspension under this section.

(d) RECORDS.—For modified loans for which suspensions under subsection (a) apply—

(1) financial institutions, including insurance companies, should continue to maintain records of the volume of loans involved; and

(2) the appropriate Federal banking agencies may collect data about such loans for supervisory purposes.

8. On April 7, 2020, the federal and state prudential banking regulators issued a revised joint statement to reflect the issuance of the CARES Act:

Interagency Statement on Loan Modifications and Reporting for Financial Institutions Working with Customers Affected by the Coronavirus (Revised)

The Board of Governors of the Federal Reserve System (FRB), the Federal Deposit Insurance Corporation (FDIC), the National Credit Union Administration (NCUA), the Office of the Comptroller of the Currency (OCC), and the Consumer Financial Protection Bureau (CFPB) (hereafter, the agencies), in consultation with the state financial regulators, are issuing this revised interagency statement to provide additional information to financial institutions that are working with borrowers affected by the Coronavirus Disease 2019 (also referred to as COVID-19). The United States has been operating under a presidentially declared emergency since March 13, 2020 (National Emergency). The agencies understand that this unique and evolving situation could pose temporary business disruptions and challenges that affect banks, credit unions, businesses, borrowers, and the economy.

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was signed into law. As discussed in more detail below, the CARES Act creates a forbearance program for federally backed mortgage loans, protects borrowers from negative credit reporting due to loan accommodations related to the National Emergency, and provides financial institutions the option to temporarily suspend certain requirements under U.S. generally accepted accounting principles (GAAP) related to troubled debt restructurings (TDR) for a limited period of time to account for the effects of COVID-19.

The agencies originally issued a statement on March 22, 2020, to encourage financial institutions to work prudently with borrowers and to describe the agencies’ interpretation of how current accounting rules under U.S. GAAP apply to certain COVID-19-related modifications. This revised interagency statement clarifies the interaction between the March 22, 2020, interagency statement and section 4013 of the CARES Act, Temporary Relief from Troubled Debt Restructurings (section 4013), as well as the agencies’ views on consumer protection considerations. The agencies will continue to communicate with the industry as this situation unfolds, including through additional statements, webinars, frequently asked questions, and other means, as appropriate.

Working with Customers: General Safety and Soundness Considerations

The agencies encourage financial institutions to work prudently with borrowers who are or may be unable to meet their contractual payment obligations because of the effects of COVID-19. The agencies view loan modification programs as positive actions that can mitigate adverse effects on borrowers due to COVID-19. The agencies will not criticize institutions for working with borrowers in a safe and sound manner. As described below, institutions generally do not need to categorize COVID-19-related modifications as TDRs, and the agencies will not direct supervised institutions to automatically categorize all COVID-19 related loan modifications as TDRs.

The agencies will not criticize financial institutions that mitigate credit risk through prudent actions consistent with safe and sound practices. The agencies consider such proactive measures to be in the best interest of institutions, their borrowers, and the economy. This approach is consistent with the agencies’ longstanding practice of encouraging financial institutions to assist borrowers in times of natural disaster and other extreme events although the agencies recognize that the effects of this event are particularly extreme and broad-based. The agencies also will not criticize institutions that work with borrowers as part of a risk mitigation strategy intended to improve an existing non-pass loan.

Financial institutions have broad discretion to implement prudent modification programs consistent with the framework included in this statement.
Accounting and Reporting Considerations

As provided for under the CARES Act, a financial institution may account for an eligible loan modification either under section 4013 or in accordance with ASC Subtopic 310-40.5 If a loan modification is not eligible under section 4013, or if the institution elects not to account for the loan modification under section 4013, the financial institution should evaluate whether the modified loan is a TDR.

Accounting for Loan Modifications under Section 4013

To be an eligible loan under section 4013 (section 4013 loan), a loan modification must be (1) related to COVID-19; (2) executed on a loan that was not more than 30 days past due as of December 31, 2019; and (3) executed between March 1, 2020, and the earlier of (A) 60 days after the date of termination of the National Emergency or (B) December 31, 2020 (applicable period).

Financial institutions accounting for eligible loans under section 4013 are not required to apply ASC Subtopic 310-40 to the section 4013 loans for the term of the loan modification. Financial institutions do not have to report section 4013 loans as TDRs in regulatory reports. However, consistent with section 4013, financial institutions should maintain records of the volume of section 4013 loans. Data about section 4013 loans may be collected for supervisory purposes. Institutions do not need to determine impairment associated with certain loan concessions that would otherwise have been required for TDRs (e.g., interest rate concessions, payment deferrals, or loan extensions). For the most recent information on reporting requirements for section 4013 loans, refer to the Federal Financial Institutions Examination Council Instructions.

Accounting for Other Loan Modifications Not under Section 4013

There are circumstances in which a loan modification may not be eligible under Section 4013 or in which an institution elects not to apply Section 4013. For example, a loan that is modified after the end of the applicable period would not be eligible under Section 4013. For such loans, the guidance below applies.

Modifications of loan terms do not automatically result in TDRs. According to ASC Subtopic 310-40, a restructuring of a debt constitutes a TDR if the creditor, for economic or legal reasons related to the debtor’s financial difficulties, grants a concession to the debtor that it would not otherwise consider. The agencies have confirmed with staff of the Financial Accounting Standards Board (FASB) that short-term modifications made on a good faith basis in response to COVID-19 to borrowers who were current prior to any relief are not TDRs under ASC Subtopic 310-40. This includes short-term (e.g., six months) modifications such as payment deferrals, fee waivers, extensions of repayment terms, or delays in payment that are insignificant. Borrowers considered current are those that are less than 30 days past due on their contractual payments at the time a modification program is implemented.

Accordingly, working with borrowers who are current on existing loans, either individually or as part of a program for creditworthy borrowers who are experiencing short-term financial or operational problems as a result of COVID-19 generally would not be considered TDRs. More specifically, financial institutions may presume that borrowers are not experiencing financial difficulties at the time of the modification for purposes of determining TDR status, and thus no further TDR analysis is required for each loan modification in the program if:

- The modification is in response to the National Emergency;
- The borrower was current on payments at the time the modification program is implemented; and
- The modification is short-term (e.g., six months).
Government-mandated modification or deferral programs related to COVID-19 would not be in the scope of ASC Subtopic 310-40, for example, a state program that requires institutions to suspend mortgage payments within that state for a specified period.

Credit Risk

The agencies’ examiners will exercise judgment in reviewing loan modifications and will not automatically adversely risk rate credits that are affected by COVID-19. All loan modifications should comply with applicable laws and regulations and be consistent with safe and sound practices (including maintenance of appropriate allowances for loan and lease losses or allowances for credit losses, as applicable). Regardless of whether modifications result in loans that are considered TDRs, section 4013 loans, or are adversely classified, agency examiners will not criticize prudent efforts to modify the terms on existing loans to affected customers.

Regulatory Capital

The FRB, the FDIC, and the OCC note that efforts to work with borrowers of one-to-four family residential mortgages as described above, where the loans are prudently underwritten, and not 90 days or more past due or carried in nonaccrual status, will not result in the loans being considered restructured or modified for the purposes of their respective risk-based capital rules.

Past Due Reporting

With regard to loans not otherwise reportable as past due, financial institutions are not expected to designate loans with deferrals granted due to COVID-19 as past due because of the deferral. A loan’s payment date is governed by the due date stipulated in the legal agreement. If a financial institution agrees to a payment deferral, this may result in no contractual payments being past due, and these loans are not considered past due during the period of the deferral.

Nonaccrual Status and Charge-Offs

Each financial institution should refer to the applicable regulatory reporting instructions, as well as its internal accounting policies, to determine if loans to stressed borrowers should be reported as nonaccrual assets in regulatory reports. However, during the short-term arrangements discussed in this statement, these loans generally should not be reported as nonaccrual. As more information becomes available indicating a specific loan will not be repaid, institutions should refer to the charge-off guidance in the instructions for the Consolidated Reports of Condition and Income.

Discount Window Eligibility

Institutions are reminded that loans that have been restructured as described under this statement will generally continue to be eligible as collateral at the FRB’s discount window based on the usual criteria.

Working with Customers: Consumer Protection Considerations

The agencies encourage financial institutions to consider prudent arrangements that can ease cash flow pressures on affected borrowers, improve their capacity to service debt, increase the potential for financially stressed residential borrowers to keep their homes, and facilitate the financial institution’s ability to collect on its loans. Additionally, such prudent arrangements may mitigate the long-term impact of this emergency on consumers by avoiding delinquencies and other adverse consequences.

When working with borrowers, lenders and servicers should adhere to consumer protection requirements, including fair lending laws, to provide the opportunity for all borrowers to benefit from these arrangements. When exercising supervisory and enforcement responsibilities, the agencies...
will take into account the unique circumstances impacting borrowers and institutions resulting from the National Emergency. The agencies will take into account an institution’s good-faith efforts demonstrably designed to support consumers and comply with consumer protection laws. The agencies expect that supervisory feedback for institutions will be focused on identifying issues, correcting deficiencies, and ensuring appropriate remediation to consumers. The agencies do not expect to take a consumer compliance public enforcement action against an institution, provided that the circumstances were related to the National Emergency and that the institution made good faith efforts to support borrowers and comply with the consumer protection requirements, as well as responded to any needed corrective action.

INT 20-03 Consensus

9. The Statutory Accounting Principles (E) Working Group reached a consensus to clarify that a modification of mortgage loan or bank loan terms in response to COVID-19 shall follow the provisions detailed in the April 7, 2020, “Interagency Statement on Loan Modifications and Reporting for Financial Institutions Working with Customers Affected by the Coronavirus” (detailed in paragraph 8) and the provisions of the CARES Act (detailed in paragraph 7) in determining whether the modification shall be reported as a troubled debt restructuring within SSAP No. 36.

10. Original Effective Date: This interpretation is effective for the specific purpose to address loan modifications in response to COVID-19. Consistent with the CARES act, this interpretation is only applicable for the term of the loan modification, but solely with respect to any modification, including a forbearance arrangement, interest rate modification, a repayment plan and other similar arrangement that defer or delays the payment of principal or interest for a loan that was not more than 30 days past due as of December 31, 2019. As determined in the CARES Act, this interpretation will only be applicable for the period beginning on March 1, 2020, and ending on the earlier of December 31, 2020, or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID–19) outbreak declared by President Trump on March 13, 2020, under the National Emergencies Act (50 U.S.C. 1601 et seq.) terminates.

11. Extension of Effective Date: On December 27, 2020, President Trump signed into law the Consolidated Appropriations Act, 2021, which slightly modified and extended the original CARES Act. These modifications included extending the provisions for temporary relief from troubled debt restructurings. Accordingly, on January 25, 2021, the provisions in this INT were extended to be applicable through the earlier of January 1, 2022, or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID–19), outbreak declared by the President on March 13, 2020, under the National Emergencies Act terminates. With this extension, this INT’s effective date corresponds with the current effective dates of the CARES Act. Unless the outbreak under the National Emergencies Act terminates, this INT and will automatically expire on January 2, 2022 (to include year-end 2021 financial statements reporting).

INT 20-03 Status

12. No further discussion is planned.
Interpretation of the Statutory Accounting Principles (E) Working Group

INT 20-07: Troubled Debt Restructuring of Certain Debt Investments Due to COVID-19

INT 20-07 Dates Discussed

May 5, 2020; May 20, 2020; January 6, 2021; January 25, 2021

INT 20-07 References

SSAP No. 26R—Bonds
SSAP No. 36—Troubled Debt Restructuring
SSAP No. 43R—Loan-Backed and Structured Securities
SSAP No. 103R—Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

INT 20-07 Issue

1. A previously unknown virus began transmitting between October 2019 and March 2020, with the first deaths in the U.S. reported in early March 2020. The disease caused by the virus is known as Coronavirus Disease 2019 (COVID-19). Several states and cities issued “stay at home” orders and forced non-essential businesses to temporarily close. This led to a significant increase in unemployment and the potential permanent closure of many businesses. Total economic damage is still being assessed; however, the total impact is likely to exceed $1 trillion in the U.S. alone.

2. In response to COVID-19, Congress and federal and state prudential banking regulators issued provisions pertaining to loan modifications as a result of the effects of COVID-19. These provisions are intended to be applicable for the term of the loan modification, but solely with respect to a modification, including a forbearance arrangement, interest rate modification, repayment plan, or other similar arrangements that defers or delays the repayment of principal and/or interest, that occurs during the applicable period for a loan that was not more than 30 days past due as of December 31, 2019.

3. On April 15, the Statutory Accounting Principles (E) Working Group issued INT 20-03T: Troubled Debt Restructuring Due to COVID-19. This interpretation provides guidance for mortgage loans and bank loans, consistent with the CARES Act and an April 7 interagency statement in recognizing troubled debt restructurings in response to COVID-19. Although the original comment letter received from interested parties proposed an expansion to all SSAP No. 26R and SSAP No. 43R debt securities, during the April 15 discussion, the comments presented from interested parties clarified their request to expand the interpretation, which was primarily related to private placement debt securities. The Working Group requested that interested parties provide more detail on this request.

4. On April 23, the interested parties submitted a comment letter requesting expansion consideration to all debt instruments in scope of SSAP No. 26R and SSAP No. 43R. In making these expanded requests, the interested parties’ comment letter stated that from a practical standpoint, actual relief will almost exclusively apply to private placement debt securities. However, by referencing “all debt securities,” it will not be necessary to provide a precise definition of a private placement debt security. In addition to considering edits for troubled debt restructuring, the comment letter also requested exceptions to impairment recognition for these securities.
5. The issues addressed in this interpretation include:

   a. Should exceptions be provided to the determination of troubled debt restructurings and impairment for all debt securities in response to COVID-19?

   b. Should exceptions be considered in the determination of troubled debt restructurings for non-public debt instruments in which the reporting entity is a direct, active, participant in the modification negotiations?

   c. Should exceptions be considered to assist with the determination of insignificant modifications in accordance with SSAP No. 36, paragraph 10?

INT 20-07 Discussion

Consideration of Exceptions for All Debt Securities

6. After evaluating the April 23 interested parties’ comment letter, this interpretation considers statutory accounting exceptions to minimize documentation and assessment requirements for specific debt securities. However, due to the importance of state regulators having accurate and reliable financial statement information, this interpretation does not propose the following:

   a. Exceptions to the recognition of a troubled debt restructuring for debt securities with modifications that result in non-insignificant concessions to a debtor that is experiencing financial difficulties.

   b. Exceptions to the assessment or recognition of impairment for debt instruments.

7. With the conclusion in paragraph 6, this interpretation does not eliminate a reporting entity’s responsibility to recognize modifications in debt instruments that to a debtor that is experiencing financial difficulties that qualify as concessions under SSAP No. 36. Furthermore, this interpretation does not delay the assessment and recognition of impairment for debt instruments that are not captured in scope of INT 20-04. As detailed above, these exceptions are not granted due to the importance of state regulators having timely, accurate and reliable financial information.

Consideration of Exceptions if the Reporting Entity is a Direct, Active Participant in Negotiating Modifications

8. Consideration was given as to whether exceptions should be provided for troubled debt restructuring and impairment assessments for situations in which the reporting entity is a direct, active participant in negotiating debt instrument modifications. However, due to the vast nature of non-public instruments that are currently classified as debt instruments that are designed in response to specific insurance reporting entity needs (such as collateralized fund obligations, principal protected notes, and other non-traditional securitizations), using direct, active participation as the sole threshold in determining whether exceptions should be granted was viewed as too expansive to ensure appropriate recognition of non-insignificant concessions and/or known impairments in the statutory financial statements.

Consideration of Provisions to Assist with Existing Troubled Debt Restructuring Guidance

9. Pursuant to existing guidance in SSAP No. 36, not all modifications are considered a troubled debt restructuring. In order to be troubled debt restructuring, a creditor, for economic or legal reasons related to the debtor’s financial difficulties, grants a concession to the debtor that it would not otherwise. As such, in order to be considered a troubled debt restructuring, the debtor must be having financial difficulties and the modification must
be considered a concession. Pursuant to paragraph 10 of SSAP No. 36, a restructuring that results in only a delay in payment that is insignificant is not a concession. The guidance also indicates that the following factors, when considered together, may indicate that a restructuring results in a delay in payment that is insignificant:

a. The amount of the restructured payments subject to the delay is insignificant relative to the unpaid principal or collateral value of the debt and will result in an insignificant shortfall in the contractual amount due.

b. The delay in timing of the restructured payment period is insignificant to any one of the following:
   i. frequency of payments due under the debt
   ii. debt’s original contractual maturity,
   iii. debt’s original expected duration.

10. Although this interpretation does not support exceptions that would result with “significant” modifications (concessions) not being recognized, from information received, differing assessments of what could be considered insignificant, and the required documentation, may be prohibitive in providing modifications. Particularly, it has been noted that the assessments are subject to auditor assessment and there are concerns that a modification considered insignificant by a reporting entity may be subsequently assessed as a significant modification by the reporting entity’s auditor.

**Practical Expedients to Assessing Concessions**

11. This interpretation, as a means of assisting with troubled debt restructuring assessments, provides limited-time practical-expedient determinants that can be used in accordance with existing SSAP No. 36 provisions in determining whether a modification shall be considered a troubled debt restructuring. These provisions are intended to assist reporting entities and auditors when considering whether a modification is insignificant. If a modification is considered insignificant, then the modification is not a concession, and recognition of a troubled debt restructuring, and disclosure is not required. If a modification does not meet the practical expedient provisions provided within this interpretation, the modification shall not automatically be considered a “non-insignificant” modification (concession). Rather, the reporting entity can continue to apply the existing guidance in SSAP No. 36 in assessing whether the modification is insignificant and is therefore not a concession. Modifications that qualify as concessions (do not qualify as insignificant) are required to follow the existing guidance in SSAP No. 36 as a troubled debt restructuring.

12. Specifically, this interpretation provides the following limited-time practical expedients:

a. Paragraph 10.a. of SSAP No. 36 identifies that restructured payments are considered insignificant if the delay is insignificant to the unpaid principal or collateral value of the debt and will result in an insignificant shortfall in the contractual amount due. For the duration of this interpretation, debt security restructurings in response to COVID-19 are considered to be insignificant if the restructuring results with a change that reflects a 10% or less shortfall amount in the contractual amount due.

b. Paragraph 10.b. of SSAP No. 36 identifies that restructured payments are considered insignificant if the delay in timing of the restructured payment period is insignificant to the frequency of payments due under the debt, debt’s original contractual maturity or the debt’s original expected duration. For the duration of this interpretation, debt security restructurings in response to COVID-
19 are considered to be insignificant if the restructuring does not result in an extension of the maturity of the debt by more than three years.

13. For the duration of this interpretation, debt security restructurings in response to COVID-19 that solely impact covenant requirements are not considered troubled debt restructurings.

**Practical Expedients on Debt Extinguishments and Exchanges**

14. In addition to the limited-time practical expedients to SSAP No. 36, this interpretation provides an exception to assess modifications as an exchange of debt instruments under paragraph 22 of SSAP No. 103R—Transfer and Servicing of Financial Assets and Extinguishments of Liabilities. Pursuant to the guidance in SSAP No. 103, debt instruments that are exchanged with substantially different terms are reported as an extinguishment and a new debt instrument. Pursuant to the provisions in this interpretation:

a. Modifications that reflect a 10% or less change in contractual cash flows considered insignificant pursuant to paragraph 12.a. do not need to be further evaluated to determine whether the modification is more than minor based on the specific facts and circumstances (and other relevant considerations) surrounding the modification. As such, these investments shall not be reported as an extinguishment and a new debt instrument.

**INT 20-07 Consensus**

15. The Working Group reached a consensus in response to requests to consider exceptions to statutory accounting guidance for troubled debt restructurings and impairment for all debt instruments. Pursuant to this consensus:

a. This interpretation does not provide exceptions to the recognition of a troubled debt restructuring for debt securities with modifications that result in non-insignificant concessions to a debtor that is experiencing financial difficulties.

b. This interpretation does not provide exceptions to the assessment or recognition of impairment for debt instruments. Pursuant to the guidance in SSAP No. 26R, after a modification for a debt instrument, assessment of OTTI shall be based on the current terms of the debt instrument.

16. In response to assessments on the application of existing SSAP No. 36 provisions, particularly in determining whether a modification is a concession (insignificant), this consensus provides the following limited-time practical expedients in determining whether a modification is a concession under SSAP No. 36:

a. Paragraph 10.a. of SSAP No. 36 identifies that restructured payments are considered insignificant if the delay is insignificant to the unpaid principal or collateral value of the debt and will result in an insignificant shortfall in the contractual amount due. For the duration of this interpretation, debt security restructurings in response to COVID-19 are considered to be insignificant if the restructuring results with a change that reflects a 10% or less shortfall amount in the contractual amount due.

b. Paragraph 10.b. of SSAP No. 36 identifies that restructured payments are considered insignificant if the delay in timing of the restructured payment period is insignificant to the frequency of payments due under the debt, debt’s original contractual maturity or the debt’s original expected duration. For the duration of this interpretation, debt security restructurings in response to COVID-
19 are considered to be insignificant if the restructuring does not result in an extension of the maturity of the debt by more than three years.

17. For the duration of this interpretation, debt security restructurings in response to COVID-19 that solely impact covenant requirements are not considered troubled debt restructurings.

18. In response to assessments on the application of existing SSAP No. 103R provisions, particularly in determining whether a modification that is not a troubled debt restructuring needs to be assessed as an exchange, this consensus provides the following exceptions to SSAP No. 103R:

   a. Modifications that reflect a 10% or less change in contractual cash flows considered insignificant under this interpretation do not need to be further evaluated to determine whether the modification is more than minor based on the specific facts and circumstances (and other relevant considerations) surrounding the modification. As such, these investments shall not be reported as an extinguishment and a new debt instrument.

   b. Modifications in response to COVID-19 that exceed the practical expedient of a 10% shortfall in contractual cash flows permitted in this interpretation that were assessed and deemed insignificant under paragraph 10 of SSAP No. 36 shall not be considered an exchange of debt instruments with substantially different terms under SSAP No. 103, paragraph 22. (Under SSAP No. 103, an exchange of debt instruments (in a nontroubled debt situation) is accomplished with debt instruments that are substantially different if the present value of cash flows under the terms of the new instruments is at least 10% different from the present value of the remaining cash flows under the terms of the original instrument.) Reporting entities shall work with auditors and regulators with the application of paragraph 10 of SSAP No. 36 to confirm that a change in contractual cash flows in excess of 10% qualifies as insignificant.

19. The Working Group highlights that modifications that would be considered troubled debt restructurings, particularly as they provide a non-insignificant concession, may be presented to the domiciliary state regulatory for a permitted practice exception to prevent troubled debt restructuring recognition and disclosure. However, the Working Group concluded that the need for reliable and accurate financial information does not permit exceptions that would allow wide-spread non-insignificant restructurings to occur and not be recognized on the statutory financial statements.

20. Original Effective Date: This interpretation is effective for the specific purpose to provide practical expedients in assessing whether modifications in response to COVID-19 are insignificant under SSAP No. 36 and in assessing whether a change is substantive under SSAP No. 103R. This interpretation will only be applicable for the period beginning on March 1, 2020, and ending on the earlier of December 31, 2020, or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID–19) outbreak declared by President Donald Trump on March 13, 2020, under the National Emergencies Act (50 U.S.C. 1601 et seq.) terminates. For clarity, this effective timeframe specifies when modifications in response to COVID-19 can be incorporated using the provisions of this interpretation. Once incorporated, the provisions of this interpretation will continue for the duration of the modification.

21. Extension of Effective Date: On December 27, 2020, President Trump signed into law the Consolidated Appropriations Act, 2021, which slightly modified and extended the original CARES Act. These modifications included extending the provisions for temporary relief from troubled debt restructurings. Accordingly, on January 25, 2021, the provisions in this INT were extended to be applicable through the earlier of January 1, 2022, or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID–19) outbreak declared by President Trump on March 13, 2020, under the National Emergencies Act.
terminates. With this extension, this INT’s effective date corresponds with the current effective dates of the CARES Act. Unless the outbreak under the National Emergencies Act terminates, this INT will automatically expire on January 2, 2022 (to include year-end 2021 financial statements reporting).

INT 20-07 Status

22. No further discussion is planned.

Application of the INT 20-07 Consensus

Example 1: Payment Holiday with Extension of Payment Term for SSAP No. 26R Instrument

A. Insurer modifies a debt instrument captured in scope of SSAP No. 26R to provide a payment holiday for 6-months in response to COVID-19. For the duration of the payment holiday, no payments are due, however the original maturity of the debt instrument has been extended from 10 years to 10 years and 6 months, with all terms and conditions remaining the same except for the payment holiday.

B. The amount of restructuring is considered insignificant as it results in a less than 10% shortfall in the contractual amount due.

C. At the time of the restructuring, fair value has dropped below amortized cost.

D. At the time of the restructuring, the reporting entity believes it is probable that the reporting entity will collect all amounts due in accordance with the modified terms of the debt instrument. Furthermore, the reporting entity does not intend to sell the instrument.

Example 1 - Application of INT 20-07

1. As this modification only extends the duration 6-months and results in a less than 10% shortfall in the contractual amount due, pursuant to the practical expedients in INT 20-07, the modification is considered insignificant and not a concession under SSAP No. 36. As this modification is not a concession, accounting and reporting as a troubled debt restructuring is not required.

2. As this modification is less than 10% of the contractual cash flows, pursuant to the practical expedients in INT 20-07, further assessment is not required to determine whether the modification is more than minor under SSAP No. 103R. As such, the modification shall not be reported as an extinguishment and a new debt instrument.

3. As the reporting entity believes it is probable that they will collect all amounts due in accordance with the modified terms of the debt instrument, no other-than-temporary impairment recognition is required under SSAP No. 26R. Future assessments of impairment will be based on the modified terms of the debt instrument.

Example 2: Reduction of Covenant Terms for SSAP No. 43R Instrument

A. Insurer modifies a debt instrument captured in scope of SSAP No. 43R to eliminate covenant terms in response to COVID-19. For the remainder of the maturity of the debt instrument, the covenant terms will reflect the modification incorporated in response to COVID-19. There has been no changes to the debt instrument with the exception of the covenant requirements.
B. At the time of the restructuring, fair value has dropped below amortized cost.

C. At the time of the restructuring, the reporting entity has the intent and ability to hold debt instrument to recover the amortized cost basis. Additionally, the reporting entity has not identified that a non-interest related decline exists.

Example 2 - Application of INT 20-07

1. As this modification only pertains to covenant components (and not the amount or timing of payments), pursuant to the practical expedients in INT 20-07, the modification is considered insignificant and not a concession under SSAP No. 36. As this modification is not a concession, accounting and reporting as a troubled debt restructuring is not required.

2. As this modification does not change the contractual cash flows, pursuant to the practical expedients INT 20-07, further assessment is not required to determine whether the modification is more than minor under SSAP No. 103R. As such, the modification shall not be reported as an extinguishment and a new debt instrument.

3. As the reporting entity has the intent and ability to hold the debt security to recover the amortized cost basis, and they have not identified a non-interest related decline, an other-than-temporary impairment is not required under SSAP No. 43R.

Example 3: Reduction in Interest Rate and Covenants for SSAP No. 26R Debt Security

A. Insurer modifies a debt instrument captured in scope of SSAP No. 26R in response to COVID-19 to eliminate interest payments for a 12-month timeframe, and to eliminate covenant requirements for the same 12-month timeframe. This change will represent an 11% shortfall of the contractual amount due.

B. At the time of the restructuring, fair value has dropped below amortized cost.

C. At the time of the restructuring, the reporting entity believes it is probable that the reporting entity will collect all amounts due in accordance with the modified terms of the debt instrument. Furthermore, the reporting entity does not intend to sell the instrument.

Example 3 - Application of INT 20-07

1. As this modification results with a 11% shortfall in the contractual amount due, the reporting entity cannot assume the change is insignificant, and therefore not a concession, under the practical expedients provided within this interpretation.

2. The reporting entity may continue to assess whether this modification is an insignificant change under paragraph 10 of SSAP No. 36. (If the reporting entity elects not to further assess for insignificance, then would proceed with considering the change as a concession.) If the reporting entity concludes that the change is insignificant, and therefore not a concession, then recognition as a troubled debt restructuring is not required. If the change is assessed as insignificant, although the change in cash flows exceeds 10%, the instrument does not need to be assessed as an exchange of debt instruments pursuant to SSAP No. 103R, paragraph 22. An OTTI is not required at the time of the modification if the reporting entity has the intent and ability to hold to recover the modified amortized cost basis and if the reporting entity has not identified that a non-interest related decline exists. Future assessments of impairment will be based on the modified terms of the debt instrument.
3. If the reporting entity concludes that the change is not insignificant under paragraph 10 of SSAP No. 36, then the modification is a concession and further assessment as a troubled debt restructuring is required. Assuming there is no collateral, a realized loss shall be recognized for the difference between fair value and amortized cost. Subsequent to this realized loss recognition, future assessments of impairment will be based on the modified terms of the debt security.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded Jan. 6, 2021. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Vice Chair (IA); Richard Ford (AL); Kim Hudson (CA); William Arfanis (CT); Rylynn Brown (DE); Eric Moser (IL); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); David Smith (VA); and Amy Malm (WI).

1. Exposed Agenda Item INT 20-03 and INT 20-07

On Dec. 27, 2020, the federal Consolidated Appropriations Act of 2021 was signed into law, which extended certain provisions of the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act. As the Working Group previously adopted two interpretations (INTs) specifically tied to the CARES Act, on Jan. 6, it conducted an e-vote to expose a possible extension of INT 20-03: Troubled Debt Restructuring Due to COVID-19 and INT 20-07: Troubled Debt Restructuring for Certain Debt Instruments Due to COVID-19 for a public comment period ending Jan. 22. A summary of the exposed INTs is as follows:

1) INT 20-03 – This INT clarifies that a modification of mortgage loan or bank loan terms in response to COVID-19 shall follow the provisions detailed in the April 7, 2020, “Interagency Statement on Loan Modifications and Reporting for Financial Institutions Working with Customers Affected by the Coronavirus,” and the provisions of the CARES Act in determining whether the modification shall be reported as a troubled debt restructuring. This INT has an effective date that mirrors the original CARES Act, and it terminated on Dec. 31, 2020. With a possible extension, the INT will be applicable through the earlier of Jan. 1, 2022, or the date that is 60 days after the date on which the national emergency concerning the COVID-19 outbreak terminates.

2) INT 20-07 – This INT provides temporary practical expedients in assessing whether modifications in response to COVID-19 are insignificant under Statement of Statutory Accounting Principles (SSAP) No. 36—Troubled Debt Restructuring and whether a modification shall be considered an exchange under SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities. This INT has an effective date that mirrors the original CARES Act, and it terminated on Dec. 31, 2020. With a possible extension, the INT will be applicable through the earlier of Jan. 1, 2022, or the date that is 60 days after the date on which the national emergency concerning the COVID-19 outbreak terminates.

Mr. Arfanis made a motion, seconded by Mr. Guerin, to expose INT 20-03 and INT 20-07 for extension consideration. The motion passed unanimously.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded Dec. 28, 2020. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Vice Chair (IA); Richard Ford (AL); Kim Hudson (CA); William Arfanis (CT); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); Melissa Greiner (PA); David Smith (VA); and Amy Malm (WI).

1. INT 20-10

As directed by the Working Group during its Dec. 18 meeting, because public comments (Attachment One-C1) were supportive of adoption, the Working Group held an e-vote to consider adoption of Interpretation (INT) 2020-10: Reporting Nonconforming Credit Tenant Loans. This INT provides a limited-time exception on the reporting of nonconforming credit tenant loans (CTLs). The temporary exception allows for continued reporting on Schedule D Part 1 – Long-Term Bonds Owned December 31 of Current Year for nonconforming CTLs that are filed with the NAIC Securities Valuation Office (SVO) by Feb. 15, 2021. This provision only requires that an entity file the security with the SVO, not that the entity receive the SVO-assigned designation prior to submitting its 2020 annual statutory financial statements. If an entity does not file with the SVO by Feb. 15, 2021, the investment shall be reported on Schedule BA – Other Long-Term Invested Assets. CTLs reported on Schedule BA are not eligible to be reported with a credit-rating provider (CRP)-determined NAIC designation.

For nonconforming CTLs that have been filed with the SVO and retained on Schedule D Part 1, the reporting entity is required to disclose the total amount of nonconforming CTLs reported on Schedule D Part 1 on Note 1 as if it were a permitted practice. The reporting entity shall complete the permitted practice disclosures required by Statement of Statutory Accounting Principles (SSAP) No. 1—Accounting Policies, Risks & Uncertainties and Other Disclosures.

Additionally, this INT provides that nonconforming CTLs that have been previously reported on a different reporting schedule may remain on the prior reporting schedule, as there is no requirement to pursue SVO-assigned designations. Reporting entities that have previously reported nonconforming CTLs on Schedule D Part 1 that do not want to file with the SVO or do not want to disclose in Note 1 are permitted to reclassify these CTLs to Schedule B – Mortgage Loans or Schedule BA without NAIC designations.

The exceptions granted in this INT are only applicable for year-end 2020 statutory financial statements. Nonconforming CTLs that have been filed with the SVO and are reported on Schedule D Part 1 shall continue Note 1 reporting for each 2021 quarterly financial statement until an SVO-assigned designation is received. The provisions within this INT and the ability to continue reporting nonconforming CTLs on Schedule D Part 1 with an SVO-assigned NAIC designation are limited time exceptions that extend only to Oct. 1, 2021.

Mr. Arfanis made a motion, seconded by Mr. Kasinow, to adopt INT 20-10 (Attachment One-C2). The motion passed unanimously.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
December 22, 2020

Mr. Dale Bruggeman, Chairman
NAIC Statutory Accounting Principles Working Group
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: Ref #2020-24 INT 20-10, Reporting Nonconforming Credit Tenant Loans (CTLs)

Dear Mr. Bruggeman

The American Council of Life Insurers (ACLI)1, Private Placement investors Association (“PPiA”)2, North American Securities Valuation Association (“NASVA”)3, and the Lease-Backed Securities Working Group4 (collectively, “the undersigned”) would like to thank the Statutory Accounting Principles Working Group

1 The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States.

2 The Private Placement Investors Association (PPiA) is a business association of insurance companies, other institutional investors, and affiliates thereof, that are active investors in the primary market for privately placed debt instruments. The association exists to provide a discussion forum for private debt investors; to facilitate the development of industry best practices; to promote interest in the primary market for privately placed debt instruments; and to increase accessibility to capital for issuers of privately placed debt instruments. The PPiA serves 44 member companies and works with regulators, NASVA, the American College of Investors Counsel, and the investment banking community to efficiently implement changes within the private placement marketplace. Learn more at www.usppia.com.

3 The North American Securities Valuation Association (NASVA) is an association of insurance company representatives who interact with the National Association of Insurance Commissioners Securities Valuation Office to provide important input, and to exchange information, in order to improve the interaction between the SVO and its users. In the past, NASVA committees have worked on issues such as improving filing procedures, suggesting enhancements to the NAIC’s ISIS electronic security filing system, and commenting on year-end processes. Find more information here

4 The Lease-Backed Securities Working Group is an industry group consisting of insurance company investors, investment bankers, attorneys and advisors. The members of the group collectively have multiple decades of experience investing in, structuring and closing over $50 billion of lease-backed financings — including Credit Tenant Loans (CTLs), Ground Lease Financings (GLFs) and other rated lease-backed securities. Over the past 30 years, principals of our group have worked closely with the NAIC SVO to devise and clarify the CTL and GLF guidelines, as well as on related efforts including matters governed by SSAP 26 and SSAP 43R.
Group (SAPWG) and NAIC Staff for the opportunity to comment on the exposed INT 20-10: Reporting Nonconforming Credit Tenant Loans.

The undersigned are supportive of SAPWG’s changes to the original INT, exposed on November 28, 2020, which extend the time horizon under which the SVO may review non-conforming CTL (i.e., for commercial lease rated lease-backed securities which are not CTLs or GLFs) filings, allow insurers to hold such securities on Schedule D-1 for year-end 2020, so long as they disclose additional information in Annual Statement, Notes to Financial Statements, Note 1 – Summary of significant Accounting Policies (“Note 1”), and allow insurers the option to hold such securities on Schedule B or BA, if they do not wish to file for an NAIC designation and provide the Note 1 disclosures. These changes provide much needed time for industry to comply with the new filing requirements and increases the likelihood that the SVO may actually be able to assign ratings designations to some of these securities within the required timeframe. It also provides capital certainty and streamlined reporting for those insurers who choose not to pursue Schedule D-1 filings. We appreciate Regulators’ and Staff’s willingness to accommodate Industry’s desire for additional time and capital relief.

As we move forward, investors may seek additional clarification from the SVO on whether or not a specific security needs to be filed. For instance, we note that there are many lease-backed securities which have been issued -- either as public bonds or 144A’s -- in the municipal taxable or tax-exempt markets which “[meet] the characteristics of a credit tenant loan”. For these deals, the subject transactions may have been issued based on a prospectus or were issued many years ago, and investors may not have access to the underlying loan-level documentation. We hope that the SVO will be able to provide individual guidance to investors in such cases.

The undersigned stand ready to help communicate this exposure broadly across Industry and to work with the SVO to resolve any operational questions or challenges that may arise, as insurers begin to comply with these new rules.

Sincerely,

Mike Monahan
Tracey Lindsey
American Council of Life Insurers
NASVA

John Petchler
John M. Garrison
on behalf of PPIA Board of Directors
Lease-Backed Securities Working Group

cc: Charles Therriault, Director, Securities Valuation Office
Julie Gann, Assistant Director, Solvency Policy

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Interpretation of the Statutory Accounting Principles Working Group

INT 20-10: Reporting Nonconforming Credit Tenant Loans

INT 20-10 Dates Discussed
Evote to Expose November 18, 2020; December 18, 2020; Evote to Adopt December 28, 2020

INT 20-04 References
SSAP No. 43R—Loan-Backed and Structured Securities


INT 20-10 Issue
1. During the Statutory Accounting Principles (E) Working Group meeting on November 12, 2020, the Working Group discussed and deferred final decision on inconsistencies in the reporting of “nonconforming” credit tenant loans (CTLs) currently reported on Schedule D-1 and directed reporting exceptions for year-end 2020. Due to subsequent questions, this interpretation has been issued to detail the provisions provided and clarify the reporting of CTLs in the year-end 2020 statutory financial statements.

INT 20-10 Discussion
2. As detailed in agenda item 2020-24, some reporting entities have reported CTLs that do not qualify as “conforming” CTLs per the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) on Schedule D-1: Long-Term Bonds. CTLs that do not qualify under the P&P Manual structural requirements are noted as “nonconforming” CTLs. During the November 12 discussion, the Working Group deferred final guidance on the reporting of nonconforming CTLs. This deferral was supported as the Working Group has a separate project to assess investments that are captured on Schedule D-1. With this project, it was identified that it would be undesirable to require an investment that is currently being reported on Schedule D-1 to be moved to a different schedule if there was potential for that investment to subsequently qualify for Schedule D-1.

3. Although the Working Group deferred final conclusion on the reporting of nonconforming CTLs, it was identified that the long-standing guidance detailed in the P&P Manual only permits CTLs that met certain structural criteria, which is verified by the SVO, to be reported on Schedule D-1. Under this existing guidance, these conforming CTLs are also prohibited from using CRP ratings in determining NAIC designation but are required to utilize SVO-assigned NAIC designations obtained after the SVO verifies compliance with the structural elements. As such, to ensure that nonconforming CTLs are not provided more favorable provisions than conforming CTLs that meet structural requirements, the Working Group confirmed that only CTLs that are filed with the NAIC SVO by February 15, 2021, shall be reported on Schedule D-1. Key aspects noted in this direction:

   a. This direction is a limited-time exception to the NAIC Policy Statement on Coordination of the Accounting Practices and Procedures Manual and the Purposes and Procedures Manual of the Investment Analysis Office and shall not be inferred to other investments. Pursuant to the noted Policy Statement, obtaining an NAIC designation does not change an investment’s applicable SSAP, annual or quarterly statement reporting schedule, or override other SSAP guidance required
for the investment to be an admitted asset. Although nonconforming CTLs will be permitted to be reported on Schedule D-1 when filed with the SVO for future receipt of an SVO-assigned NAIC designation (even without meeting structural requirements), this is strictly a limited-time exception to prevent reporting schedule changes while a larger project on the scope of Schedule D-1 is considered.

b. The requirement to file the nonconforming CTL for an SVO-assigned NAIC designation for Schedule D-1 applies to all investments that represent credit tenant loans. It is not permissible for a reporting entity to classify an investment, which meets the characteristics of a credit tenant loan, as a different type of investment (for example, as a form of leased-backed security) for purposes of reporting the investment on Schedule D-1 without filing for an SVO-assigned NAIC designation.

c. The Working Group direction intends to only address nonconforming CTLs that have previously been reported on Schedule D-1 although they did not comply with the requirements of the P&P Manual. This direction is not intended to require, or permit, nonconforming CTLs that have been previously reported as mortgage loans (on Schedule B – Mortgage Loans) or as other invested assets (on Schedule BA – Other Long-Term Invested Assets) to be moved to a different reporting schedule. Nonconforming CTLs that have previously been reported on Schedule B or BA shall remain on that reporting schedule for the duration of this INT.

INT 20-10 Consensus

4. The Working Group reached a consensus to provide a limited time exception allowing nonconforming CTLs to continue to be reported on Schedule D-1 for year-end 2020 provided they have filed for an SVO-assigned NAIC designation. With the issuance of this interpretation, the Working Group confirmed the provisions and limitations detailed in paragraph 3, and summarized the resulting provisions below:

a. CTLs that qualify per the provisions of the P&P Manual are considered to be “conforming” CTLs and shall be reported on Schedule D-1 with the NAIC designation obtained from the SVO.

b. CTLs that do not qualify per the provisions of the P&P Manual to be “conforming”CTLs shall follow the accounting and reporting provisions detailed in the following subparagraphs. These CTLs are noted as “nonconforming CTLs.”

i. Nonconforming CTLs that have previously been reported on Schedule D-1 may continue to be reported on Schedule D-1 for year-end 2020 if they have filed for an SVO-assigned NAIC designation. This provision only requires that an entity file the security with the SVO by February 15, 2021, not that the entity receive the SVO-assigned designation prior to submitting their 2020 annual statutory financial statements. If an entity does not file the security with the SVO by February 15, 2021, the investment shall be reported on Schedule BA. If reporting on Schedule BA, these CTLs shall not be reported with a credit-rating provider (CRP) determined NAIC designation. For nonconforming CTLs that have been filed with the SVO and retained on Schedule D-1, the reporting entity is required to disclose the total amount of nonconforming CTLs reported on Schedule D-1 on Note 1 as if it were a permitted practice. The reporting entity shall complete the permitted practice disclosures required by SSAP No. 1—Accounting Policies, Risks & Uncertainties, and Other Disclosures, with two separate entries that detail the nonconforming CTLs that were reported on D-1 on one line, and the nonconforming CTLs that were not reported on.
Schedule BA on a separate line within this disclosure. (These lines will likely net to a zero impact to statutory surplus; therefore, the separate line reporting is required.)

ii. Nonconforming CTLs that have been previously reported on a different reporting schedule (e.g., Schedule B or Schedule BA) shall remain on the prior reporting schedule. There is no requirement for reporting entities to pursue SVO-assigned designations for these CTLs or disclose these nonconforming CTLs in Note 1. Furthermore, reporting entities that have previously reported nonconforming CTLs on Schedule D-1 that do not want to file with the SVO or that do not want to disclose in Note 1 pursuant to paragraph 4.b.i. are permitted to reclassify these CTLs to Schedule B or Schedule BA without NAIC designations.

5. The exceptions granted in this interpretation are applicable for the year-end 2020 statutory financial statement only. Nonconforming CTLs that have been filed with the SVO and are reported on Schedule D-1 shall continue the Note 1 reporting for each 2021 quarterly financial statement until an SVO-assigned designation is received. The provisions within this INT, and the ability to continue reporting nonconforming CTLs on Schedule D-1 with an SVO-assigned NAIC designation, are limited time exceptions that extend only to October 1, 2021. The exceptions provided in this INT shall not be interpreted to indicate the likely conclusion of the Working Group in determining the appropriate reporting schedule for nonconforming CTLs. All reporting entities shall be prepared to make adjustments to comply with the reporting schedule utilized for nonconforming CTLs upon final conclusion by the Working Group.

INT 20-10 Status

6. On November 18, 2020, the Statutory Accounting Principles (E) Working Group exposed this interpretation to provide a limited-time exception on the reporting of nonconforming CTLs. On December 18, 2020, the Working Group exposed revisions to this interpretation to allow continued D-1 reporting of nonconforming CTLs if they are filed with the SVO by February 15, 2021. With this provision, nonconforming CTLs reported on Schedule D-1 that have not received an SVO-assigned designation shall be disclosed in Note 1 as if a permitted practice. On December 28, 2020, the Working Group finalized action, via evote, to adopt the interpretation exposed December 18, 2020.

7. No further discussion is planned.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force met Dec. 18, 2020. The following Working Group members participated: Dale Bruggeman, Chair (OH); Carrie Mears and Kevin Clark, Co-Vice Chairs (IA); Richard Ford (AL); Kim Hudson (CA); William Arfanis (CT); Rylynn Brown (DE); Kevin Fry (IL); Caroline Fletcher (LA); Kristin Hynes (MI); Doug Bartlett (NH); Bob Kasinow (NY); Kimberly Rankin (PA); Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. Reviewed Comments on Exposed Items

The Working Group held a public hearing to review comments (Attachment One-D1) on previously exposed items.

a. INT 20-11

Mr. Bruggeman directed the Working Group to Interpretation (INT) 20-11: Extension of Ninety-Day Rule for the Impact of 2020 Hurricanes, California Wildfires and Iowa Windstorms. He stated that in response to a higher catastrophe year, this INT provides a 60-day extension from the 90-day rule for uncollected premium balances, bills receivable, and amounts due from agents and for policies directly impacted by the noted 2020 hurricanes, California wildfires and Iowa windstorms. He stated that the INT expires Feb. 28, 2021, to allow for year-end 2020 application. In response to an inquiry from Mr. Bruggeman, Robin Marcotte (NAIC) stated that there were no comments received on this exposed INT. As this INT provides a temporary exception to the 90-day rule, the NAIC Policy Statement on Maintenance of Statutory Accounting Principles requires a two-thirds supermajority vote for adoption by the Working Group.

Ms. Malm made a motion, seconded by Mr. Hudson, to adopt INT 20-11, providing limited time exceptions to the 90-day rule in Statement of Statutory Accounting Principles (SSAP) No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers (Attachment One-D2). The motion passed unanimously. Ms. Marcotte stated that INT 20-11 will be publicly posted on the Working Group’s webpage.

b. INT 20-10

Mr. Bruggeman directed the Working Group to INT 20-10: Reporting Nonconforming Credit Tenant Loans (CTLs). He stated that the Working Group met in public forum Nov. 12 and adopted guidance for the accounting and reporting of nonconforming CTLs for year-end 2020; however, due to inquiries received subsequent to that meeting, NAIC staff drafted the INT for clarity purposes and conducted an evote on Nov. 18 to expose the INT for public comment. (Attachment One-D3). As the INT reflects the Working Group’s previous action, the adoption can occur with a single majority vote, whereas changes to the INT will require a two-thirds majority vote for adoption in accordance with the NAIC Policy Statement on Maintenance of Statutory Accounting Principles.

Julie Gann (NAIC) stated that the original agenda item, 2020-24 Accounting and Reporting of Credit Tenant Loans, was initially drafted in response to a Valuation of Securities (E) Task Force referral regarding the accounting and reporting of nonconforming CTLs, which had incorrectly been captured in Schedule D, Part 1, Long-Term Bonds Owned December 31 of Current Year. She stated that the original agenda item exposed two options for the reporting of nonconforming CTLs. The first option is to reaffirm that the reporting of conforming CTLs were in scope of SSAP No. 43R—Loan-Backed and Structured Securities to be reported on Schedule D, Part 1. However, this option clarified that the reporting of nonconforming CTLs should occur on either Schedule B as a mortgage loan or on Schedule BA as an other invested asset. The second option was to classify all CTLs on Schedule BA as an other invested asset. Ms. Gann stated that despite these two initial options, the Nov. 12 decision of the Working Group was to allow an exception for year-end reporting, permitting nonconforming CTLs to remain on Schedule D, Part 1 only if they receive an assigned designation from the NAIC Securities Valuation Office (SVO). She stated that this option is preferred by the Working Group so nonconforming CTLs would not receive better treatment than conforming CTLs, as conforming CTLs are required to be filed with the SVO and receive a designation. In this decision, nonconforming CTLs that do not receive an SVO designation for any reason are to be reported on Schedule BA subject to a 30% capital charge.
Additionally, the Working Group decided that for entities reporting nonconforming CTLs on Schedules B or BA, continued reporting on these schedules should occur, and filing with the SVO would not be required.

Ms. Gann stated that comments received from the industry “Lease-Backed Securities Working Group” proposed several requests: 1) consideration that if the Working Group ultimately decides that nonconforming CTLs are in scope of SSAP No. 43R, they will remain filing exempt (FE), meaning the nonconforming CTLs can be reported with a credit rating provider (CRP) rating rather than require analysis by the SVO; 2) an extension of the Dec. 31, 2020, filing deadline for these types of securities; and 3) specifying that if nonconforming CTLs are moved to Schedule BA, they will be permitted to retain their bond-equivalent capital charge based on their current CRP ratings. In response to these requests, she stated that consideration on whether a nonconforming CTL would be FE eligible is a decision of the Valuation of Securities (E) Task Force, and it will not be in the purview of the Working Group. Additionally, the referenced Dec. 31, 2020, filing deadline was not published by either the SVO or in the INT. The prior discussion indicated only that the SVO designation would need to be received before the statutory financial statements are filed. Finally, NAIC staff did not recommend that the Working Group allow for bond-equivalent risk-based capital (RBC) charges on Schedule BA, as that would allow for reporting optionality. An entity could, in effect, choose which nonconforming CTLs to file with the SVO for Schedule D, Part 1 reporting and elect to report others on Schedule BA with an equivalent capital charge based on CRP ratings. Ms. Gann stated that additional comments, while not reflected in the hearing agenda due to the timing of receipt, were received from the Private Placement Investors Association (PPIA). The PPIA comments in the meeting attachments recommend delaying the proposal until after year-end 2020. If delaying is not an option, the PPIA would then recommend optionality in reporting on either Schedule D, Part 1 or Schedule BA. Finally, if neither of these options are acceptable, the PPIA would request that the Working Group consider that all nonconforming CTLs be reported on Schedule BA, with an RBC charge commensurate to the securities’ CRP rating. Ms. Gann stated that reporting on Schedule BA with an RBC charge driven by a CRP rating was the original suggestion offered by NAIC staff on the Nov. 12 call; however, the motion that occurred for that action failed for lack of a second by the Working Group.

John Garrison (Lease-Backed Securities Working Group) stated appreciation for several previous Working Group decisions regarding the accounting and reporting of CTLs, including: 1) reporting conforming CTLs on Schedule D, Part 1; and 2) requesting analysis on whether the 5% uninsured residual asset risk threshold should be examined. He stated that the 5% threshold was established nearly 20 years ago; it was arbitrary at the time; and as other investment types possess residual risk greater than 5%, CTLs should benefit from a reexamination so that they are on an even playing field with other similar investment types. Additionally, he stated appreciation for the Working Group delay of the accounting and reporting determination of nonconforming CTLs until a final decision can be made regarding the definition of a bond in conjunction with the ongoing SSAP No. 43R/Schedule D, Part 1 project. He stated that in response to the requirement to file these investments with the SVO, many logistical issues have been discovered that are causing difficulties with filing. Examples include contracts not being in electronic form and in off-site storage to the length of documents, causing difficulty with submission to the SVO. Mr. Garrison stated that in addition, many reporting entities close their books early in January, which makes the requirement to receive an SVO-designation before filing not feasible for year-end 2020 reporting. He stated that due to year-end timing, combined with the logistical issues, and with the SVO having to designate an unknown number of nonconforming CTLs, the decision to require filing for 2020 is not feasible. He stated that with the proposal to move nonconforming CTLs to Schedule BA and be subject to a 30% capital charge, a charge equivalent to equity investments or default debt does not accurately reflect the economics of the transaction, as no evidence has been presented that these items have caused a negative credit or a solvency issue for a reporting entity. Additionally, many of these securities have been reported on Schedule D, Part 1 for up to 15 years, all without previous scrutiny or concern. Mr. Garrison stated in response to NAIC staff’s comments regarding optionality in reporting, that he believes the SVO will determine Schedule D, Part 1 or Schedule BA reporting, not the reporting entity itself. He stated that the Lease-Backed Securities Working Group supports filing these items with the SVO; however, an interim 30% capital charge would be an unfair outcome. Mr. Fry, in response to an inquiry from Mr. Bruggeman, stated that if a deferral for year-end reporting is permitted, a deadline should be required for filing with the SVO, as all CTLs should require an NAIC SVO-assigned designation for 2021 reporting. Mr. Bruggeman stated that if deferred for year-end 2020, nonconforming CTLs should still be filed with the SVO by a filing deadline to be reported in the 2020 year-end financial statements on Schedule D, Part 1, even if the SVO has not provided the SVO-assigned designation.

Mr. Smith inquired about whether nonconforming CTLs are incorrectly being reported on Schedule D, Part 1 and whether a deferral would simply allow these items to improperly remain on Schedule D, Part 1. Mr. Bruggeman stated that through recent developments, it was discovered that nonconforming CTLs have been reported on Schedule D, Part 1, primarily due to an interpretation that these items, in good faith, are believed to be FE securities. Additionally, the timing required to receive an SVO-assigned designation, required for Schedule D, Part 1 reporting, is no longer feasible for year-end 2020. Mr. Bruggeman stated that the final result of the nonconforming CTL issue should be considered in conjunction with the ongoing SSAP No.
43R/Schedule D, Part 1 project. Ms. Gann stated that due to the legal structure of these investments being classified as securities, they are not eligible for SSAP No. 37—Mortgage Loans; thus, this caused uncertainty with their applicable SSAP and reporting location, with some reporting entities concluding that they were Schedule D, Part 1 eligible. In a response to an inquiry from Mr. Smith, Charles Therriault (NAIC) stated that a small number of nonconforming CTLs have been filed with the SVO, and more are anticipated. Mr. Arfanis stated support for deferral of a final decision regarding the reporting of nonconforming CTLs, but he would support special identification of such items in the year-end financial statements.

Sasha Kamper (American Equity), representing the PPIA, stated that the PPIA consists of 55 members, most of whom are U.S. domiciled insurance companies that invest regularly in the private placement debt market, including CTLs. She stated that the PPIA appreciates that the Nov. 12 Working Group call was an attempt to accommodate various industry requests; however, further review of the guidance has identified additional concerns. She stated that the INT requires insurers who have previously been carrying nonconforming CTLs on Schedule D, Part 1 to file all of these securities with the SVO immediately so that the SVO can review and decide whether to assign a NAIC designation to such securities on or before March 1, 2021. She stated that many reporting entities close their books in early January and would not be able to file the necessary documentation and receive a definitive answer in time to close the financial statements. Additionally, many records are in off-site storage or are so large that expedited filing with the SVO has proved difficult. Ms. Kamper also stated that there is industry concern regarding the SVO’s ability to timely analyze and assign ratings for nonconforming CTLs. She stated that the SVO does not have an approved rating methodology, and when combined with the volume of details in each investment, difficulties in assigning a designation will occur. She stated that industry should be able to file all required documentation by the first quarter of 2021, and she would be supportive of a deferral until year-end 2021. She stated that the PPIA also has concerns regarding the proposed 30% capital charge if reported on Schedule BA, which would cause a major deterrent in the marketplace. She stated that these investments are not as volatile as equity investments, and they are akin to mortgage loans, which are only subject to a 5–7% capital charge. Requiring a 30% capital charge on a strong asset class would be punitive to investors. Ms. Kamper stated that in summary, the PPIA would support deferral or bifurcated reporting on Schedule D, Part 1 and Schedule BA with adjusted capital charge treatment, and if neither of these options were supported, she would request consideration for all nonconforming CTLs to be reported on Schedule BA with adjusted capital charge treatment. Mr. Bruggeman stated that he understands the PPIA’s request as: 1) deferral with special identification of nonconforming CTLs in the year-end investment schedules; 2) bifurcated reporting on Schedule D, Part 1 (with an SVO-assigned designation) or Schedule BA with bond capital charge treatment; or 3) all nonconforming CTLs moved to Schedule BA with bond capital charge treatment. Mr. Garrison inquired about whether a capital charge “haircut” on Schedule BA could be considered, so if a bifurcated reporting approach is not approved by the Working Group, a capital charge less than 30% could be considered. Mr. Bruggeman stated that capital charges are not in the purview of the Working Group, and bifurcated reporting is not preferred, as it does allow for optionality in reporting. He stated that the main issue is for nonconforming CTLs to be reviewed with designations received from the SVO.

Mr. Clark stated that based on the responses received, the timing of filing remains the primary issue. He stated that from a long-term perspective, receiving SVO-assigned NAIC designations is the primary goal. However, in an effort to not overly complicate a solution, he said he would support deferral of this topic with a filing deadline that can be practically achieved in the current environment. In response to an inquiry from Mr. Fry, Ms. Gann stated that if the Working Group were to support Schedule BA reporting, a specific reporting line would be utilized to allow bond-like capital treatment based on the CRP rating; i.e., not subject to a 30% capital charge. Mr. Bruggeman stated that based on regulator discussions, Schedule D, Part 1 reporting does not appear to be the primary concern. The primary concern is related to the timing of filing and receipt of SVO-assigned designations. Mr. Bruggeman stated that a deferral could be considered with special identification of nonconforming CTLs in Note 1 of the financial statements. As this is a one-time special consideration, this note could be utilized to identify the amount of nonconforming CTLs reported in Schedule D, Part 1. This provision would only be allowed if the securities are filed for review, even if designations are not received before the statutory financial statements are filed with the NAIC. In response to an inquiry from Mr. Smith, Mr. Bruggeman stated that Schedule D, Part 1 reporting could be allowed with the continued use of Note 1 until the SVO has assigned a designation.

Mr. Bruggeman stated that due to the change in direction, he would recommend an exposure of a new INT documenting deferral of moving nonconforming CTLs from Schedule D, Part 1, subject to filing requirements. He stated that due to year-end, the timing of an exposure period would need to be minimal. Michael Monahan (American Council of Life Insurers—ACLI) stated that the ACLI would be supportive of an expedited exposure period of an INT supporting deferral of moving nonconforming CTLs from Schedule D, Part 1.

Ms. Gann electronically displayed a draft INT supporting deferral of moving nonconforming CTLs from Schedule D, Part 1. Mr. Bruggeman stated that he proposed a filing deadline of Feb. 15, 2021. As such, to continue reporting on Schedule D, Part
1, a reporting entity would have to file the nonconforming CTL with the SVO by Feb. 15, 2021. The INT only requires that an entity file the security with the SVO by Feb. 15, 2021, not that the entity receive the SVO-assigned designation prior to submitting their 2020 annual statutory financial statements. If an entity does not file the security with the SVO by Feb. 15, 2021, the investment shall be reported on Schedule BA, and it would not be reported with a CRP-determined NAIC designation, thus the CTL would be subject to a 30% capital charge. In addition, for nonconforming CTLs that have been filed with the SVO and retained on Schedule D, Part 1, the reporting entity is required to disclose the total amount of nonconforming CTLs reported on Schedule D, Part 1 in Note 1 as if it were a permitted practice. The reporting entity shall complete the permitted practice disclosures required by SSAP No. 1—Accounting Policies, Risks & Uncertainties and Other Disclosures, with two separate entries that detail the nonconforming CTLs that were reported on Schedule D, Part 1 on one line and the nonconforming CTLs that were not reported on Schedule BA on a separate line within this disclosure. Two lines are required in the disclosure to reflect the detail, as it is expected that there would be a net zero impact to statutory surplus. Ms. Gann stated that the INT also includes provisions for reporting entities that previously reported nonconforming CTLs on Schedule D, Part 1 that do not want to file with the SVO or do not want to disclose in Note 1. With the provisions, these entities are permitted to reclassify these CTLs to Schedule B or Schedule BA without NAIC designations. Ms. Gann stated that the effective date of the INT would apply for year-end 2020 and expire after third-quarter 2021 reporting.

Mr. Bruggeman stated that this INT would defer the final reporting schedule for nonconforming CTLs, but it would allow Schedule D, Part 1 reporting if the investments are filed with the SVO by the Feb. 15, 2021, deadline. Additionally, it would require Note 1 to be completed, detailing the amount of nonconforming CTLs reported in Schedule D, Part 1. He stated that to expedite potential adoption, if public comments are not contrary to adoption or do not propose significant edits, an email vote may occur. However, if substantial comments are received, a public call will be scheduled. Mr. Monahan stated that the INT will likely be conceptually supported, and it is not expected that industry would not provide substantial comments to the contrary. Mr. Clark made a motion, seconded by Mr. Hudson, to expose INT 20-10 for a public comment period ending Dec. 22. The motion passed unanimously.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
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The Lease-Backed Securities Working Group

To: Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group

Re: Minutes of the November 12th Meeting of the Statutory Accounting Principals Working Group & Interpretation 20-10: Accounting and Reporting of Non-conforming Credit Tenant Loans

Dear Mr. Bruggeman:..............................

We have reviewed the minutes from the November 12th meeting of the Statutory Accounting Principles Working Group, and the Interpretation, INT 20-10, prepared by staff summarizing the conclusion that was reached in that meeting on the reporting of “non-conforming CTLs” (agenda item 2020-24). (For reference, we have attached an excerpt from the minutes to this letter.)

Based on our review, we note the following:

- The Interpretation correctly states the “the Working Group deferred final guidance on the reporting of non-conforming CTLs...as the Working Group has a separate project to assess investments that are captured on Schedule D-1. With this project it was identified that it would be undesirable to require an investment that is currently being reported on Schedule D-1 to be moved to a different schedule if there was the potential for that investment to subsequently qualify for Schedule D-1”.

  In addition, with regard to the filing of existing transactions on investors books for the current calendar year, the Interpretation correctly states that “Nonconforming CTLs that have previously been reported on Schedule D-1 may continue to be reported on Schedule D-1 if they receive an SVO-assigned NAIC designation”.

- The minutes include the requirement for “all nonconforming CTLs to be filed immediately with the SVO [in order] to remain on Schedule D-1......If the nonconforming CTLs are not filed or have not received an NAIC SVO designation before the March 1, 2021 filing date, the securities shall be reported on Schedule BA.”

However, we seek clarification on several issues:

1.) Based on the above, it seems clear that while no final decision is being made at this time, notwithstanding that some “nonconforming CTLs” — namely those that do not receive an SVO-assigned NAIC designation -- may be moved to Schedule BA for some interim period pending the outcome of the Schedule D-1 project (formerly the “43R Project”), that to the extent that so-called “nonconforming CTLs” are ultimately determined to be Schedule D-1 eligible bonds, they would then revert to Schedule D-1 as filing exempt securities if they have received an eligible CRP rating.

2) Not explicitly discussed in the November 12th meeting was the RBC charge to be assigned to those securities previously reported on Schedule D-1 and subsequently moved to BA. The Interpretation states that “these [BA] CTLs shall not be reported with a credit-rating provider (CRP) determined
The Lease-Backed Securities Working Group

NAIC designation.” Presumably, based on this interpretation, those securities which are moved from Schedule D-1 to Schedule BA would receive a 30% RBC charge – equivalent to defaulted debt.

In addition, the Interpretation also states that “if an SVO-assigned designation cannot be obtained for any reason, which includes situations in which the SVO determines that it cannot provide an NAIC designation…..the investment shall be reported on Schedule BA”.

Read literally, this raises the possibility that these performing assets could receive a 30% capital charge – equivalent to defaulted debt – for any number of reasons, including an inability on the part of investors to meet the filing deadline -- or simply the inability of the SVO to get to certain transactions by the March 1st deadline. This would be unfairly punitive to a performing asset class, and patently unfair to insurance company investors who have been reporting these transactions as Schedule D-1 investments in good faith for years.

3.) With regard to timing, we note that the SVO just posted – on December 4, 2020 – its filing instructions for these transactions. The instructions are for Conforming CTLs (not Non-Conforming CTLs, for which no current form exists) run to eight pages and include the requirement to provide the SVO with all the major legal documents related to a transaction, including appraisals, environmental reports, etc. – a document package that could run to hundreds of pages of legal and other documents. For many investors with old deals on their books, these documents may be stored off-site, and even if available, are often not in electronic form. It may not be possible for investors to compile and make copies of and submit all these documents in the short time available. Our group has received many inquiries from investors who have not been following the CTL discussion closely, and who are confused about exactly what they are required to do – even as to what constitutes a “non-conforming CTL”.

We note further that in the November 12 meeting, Chairman Fry made the comment that “It’s important that these [non-conforming CTLs] don’t get put on BA and have a 30% capital charge put on them – I don’t think we’re recommending that.”

In a recent conversation we had with Chairman Fry, he suggested that an alternative to this outcome would be to move the non-designated transactions to Schedule BA, but that they would continue to receive their bond equivalent capital charges based on their current CRP ratings.

We would ask the Working Group to consider the following:

1.) That the final decision as to the appropriate accounting and reporting requirements for the “non-conforming CTL” transactions will be included in and made part of the Schedule D-1 Project (formerly the “43R Project) and that to the extent that so-called “nonconforming CTLs” are ultimately determined to be Schedule D-1 eligible bonds, they would then revert to Schedule D-1 as filing exempt securities if they have received an eligible CRP rating.

2.) To amend the Interpretation to specify that those transactions which are re-classified to Schedule BA for the current reporting year be allowed to be reported using their bond-equivalent capital charges based on their current CRP ratings, pending the final outcome of the Schedule D-1 project.
3.) Extending the December 31st deadline for investors to submit these securities to the SVO,

We would ask the Working Group to consider amending the Interpretation to reflect the foregoing points.

Realizing that approval of the current language in the Interpretation may occur via an “e-mail vote”, there is limited opportunity for discussion or for us to raise this issue with the members of the Working Group. However, our goal – as always – is to make sure that the system operates as fairly and transparently as possible for all participants, and to avoid creating confusion in the markets. We would hope that the members of the Working Group would have an opportunity to discuss our comments in advance of a final approval vote on the “Interpretation”.

We thank you for considering our comments.

John Garrison,
On behalf of the Lease-Backed Securities Working Group

Attachment:

From the minutes for the November 12, 2020 SAP Working Group Meeting:

“Mr. Fry made a motion, seconded by Mr. Clark, to require all nonconforming CTLs to be immediately filed with the SVO to remain on Schedule D-1. However, Schedule BA reporting will be required for those who are unable or will not file. Charles Therriault (NAIC) stated that while the SVO would consider an existing nationally recognized statistical rating organization’s (NRSRO’s) report for nonconforming CTLs, the SVO has not developed a methodology for assigning designations to such items. Mr. Bruggeman stated the motion included all the following elements: 1) confirm that conforming CTLs will remain in scope of SSAP No. 43R and reported on D-1; 2) direct a referral to the SVO to request information on the residual risk percentage permitted to be considered a conforming CTL; and 3) permit nonconforming CTLs filed with the SVO that receive an SVO-assigned NAIC designation to be reported on Schedule D-1. If the nonconforming CTLs are not filed or have not received a NAIC SVO designation before the March 1, 2021, filing date, the securities shall be reported on Schedule BA. The motion passed unanimously.”
December 15, 2020

Mr. Dale Bruggeman, Chair  
Ms. Carrie Mears, Vice-chair  
NAIC Statutory Accounting Principles (E) Working Group (“SAPWG”)  
1100 Walnut Street  
Suite 1500  
Kansas City, MO 64106-2197

Dear Mr. Bruggeman and Ms. Mears:

The Board of Directors of the Private Placement Investors Association (“PPIA”) appreciates the opportunity to provide comment on “INT 20-10: Reporting Nonconforming Credit Tenant Loans.” Such investments are held by many of our 55 member companies, most of whom are US-domiciled insurance companies that invest regularly in the private placement debt market, including in Credit Tenant Loans (“CTLs”).

The PPIA understands that this exposure is an interpretation of discussion from a mid-November SAPWG meeting and resulted from NAIC Staff’s and Regulators’ desire to work with insurers to find a temporary solution for reporting non-conforming CTLs and to possibly provide capital relief. We know that the NAIC has been in multi-year discussions with Industry regarding these securities, and we appreciate your genuine willingness to accommodate insurers’ needs and look for a mutually agreeable solution. That said, we do have two concerns around the non-conforming CTL proposal which we will detail below. We would also like to offer a solution which we believe would help alleviate both concerns and help move the process forward.

Timing

The interpretation requires insurers who have previously been carrying non-conforming CTLs on Schedule D-1 to file all of these securities with the SVO immediately, so that the SVO can review and decide whether to assign an NAIC designation to such securities on or before March 1, 2021. This timing is challenging, as it results in a major reporting change and significant new filing requirements for insurers right before year-end. It also places a significant burden on the SVO staff to review and attempt to assign designations to such securities in a short time window.

The PPIA has begun telegraphing these new rules to our member companies; however, the change has resulted in multiple questions and a lot of confusion around which deals need to be filed, what is required to be filed as supporting documentation, the timing of such filings, whether the ruling was intended to be prospective or retrospective, and what criteria the SVO will use to assign designations to these investments. Given the nature and volume of questions, we expect that there will be a variety of inconsistent responses from insurers at year-end, with some complying fully with the new proposal, some complying partially but perhaps without a full
understanding of which CTLs are necessary to file, and some not even aware of the new requirements. The fact that certain insurers will be allowed to continue carrying these securities on Schedule B or BA, while others must file for Schedule D-1 treatment and then hold on Schedule BA, if the SVO cannot assign a designation for any reason, only adds to this confusion.

Other challenges include assembling the documents needed to support the filings. Some of these securities have been on insurers’ books for 15+ years, and insurers may not have documentation stored electronically, such that it’s easy to upload requirements into the NAIC’s systems. In these situations, insurers are forced to retrieve documents from off-site paper storage warehouses, which takes time and reduces the likelihood that such filings can be submitted before year-end. This issue is exacerbated by the current work-from-home conditions under which most insurers are still operating.

The PPiA is also concerned that this will be a first-time filing for many of these securities, and that the requested list of supporting documents for such filings is extensive. (For example, once such transaction that the PPiA is currently aware of has a closing documents package from outside counsel that is 256MB and cannot be sent over email—instead, investors must access these files from an electronic DropBox.) While the PPiA appreciates the SVO’s effort to try and review as many of these transactions as possible between now and March 1st, as a practical matter, we believe it will be extremely difficult for the SVO Staff to review most of these investments and assign designations in this short timeframe. The fact that the SVO currently has no rating methodology criteria in place to assess the risks associated with these securities compounds the difficulties. The PPiA is concerned that the SVO will either not be able to review many of these securities in the allotted timeframe, or that the SVO will be unable to designate such securities without some pre-existing rating methodology in place, and many of these deals will be relegated to Schedule BA reporting with onerous capital treatment (see RBC concerns below).

For the reasons stated above, the PPiA believes it would be best to delay implementation of the new rules from year-end 2020 into 2021. Industry is willing to begin filing all non-conforming CTLs with the SVO to provide transparency for Regulators, and we are willing to work with the SVO to discuss and develop a potential ratings framework in early 2021, so that many of these securities could be designated over the course of the full year. However, we believe that it is too late in the year to adopt new reporting requirements that could potentially have negative capital consequences for insurers, and we think that more time would allow a more thoughtful approach to review such securities and implement the new rules smoothly. As such, we would ask Regulators to consider delaying the reporting and RBC requirements change until year-end 2021. However, if Regulators are unwilling to delay implementation of such rules changes, then the PPiA would ask for relief on the RBC requirement as noted below.

**RBC Requirements**

As discussed above, the PPiA believes that these new interim rules will result in many of the non-conforming CTL transactions moving to Schedule BA, either because the SVO lacks sufficient time to review the investments, or because the SVO is unable to assign a designation without a pre-defined ratings methodology framework. The PPiA’s interpretation of INT 20-10 is that such securities, if reported on Schedule BA, would be assessed a 30% C1 RBC charge. This capital charge is typically assigned to equity securities and limited partnership investments and seems overly conservative for securities which are—at worst—mortgages with a 20-year fixed-income cash...
flow payment stream derived from an investment grade tenant(s). We note that the current discussions around non-conforming CTLs originated from a desire to provide capital relief for these securities, which were previously reported on the Schedule B (the commercial mortgage schedule). However, absent some form of additional capital relief, any non-conforming CTLs that are reported on Schedule BA would be forced to carry more than 5x the capital vs. if such securities were reported on Schedule B with the requisite commercial mortgage RBC charges. A 30% RBC C1 charge for these securities is not a desirable outcome for PPIA members or for their respective policyholders. Therefore, we would ask that SAPWG make an exception to allow any non-conforming CTLs reported on Schedule BA to carry bond RBC treatment, based on the credit ratings assigned to such securities by a CRP. We understand that such a request is a departure from historical NAIC policy regarding CTLs and would be a temporary exception, limited to only non-conforming CTLs, but we believe such an exception makes sense, given the tight timing for implementing these new rules, and given that this issue will be revisited later, in conjunction with projects to rewrite SSAP No. 43R and to provide a more robust definition of a bond in the SSAPs.

The PPIA understands that some Regulators may be uncomfortable with allowing some non-conforming CTLs to be carried on Schedule D-1 (those for which the SVO assigns a designation), while allowing other non-conforming CTLs to be reported on Schedule BA, yet still carry a bond RBC charge. Such Regulators have stated a preference for an “either/or” approach, rather than providing insurers with “the best of both worlds” (i.e. Schedule D for some securities, and Schedule BA with bond RBC charges for others). If this is truly the case, and Regulators can only see fit to approve one reporting option that grants bond RBC treatment for non-conforming CTLs, then the PPIA requests that all non-conforming CTLs be reported on Schedule BA with the exception granted for bond RBC treatment, based on assigned CRP ratings. The PPIA feels strongly that a 30% RBC charge is a punitive outcome and not appropriate for the risk associated with these securities. As such, we would prefer less punitive capital treatment for the full universe of these securities rather than Schedule D-1 reporting for some (but not all) non-conforming CTLs.

The PPIA shares the NAIC’s desire to provide clarity around this issue and to move forward. We hope to work constructively with the NAIC Staff and with Regulators to develop a final solution that is mutually agreeable and reasonably reflects/reports the risks associated with non-conforming CTLs. However, it is our strong desire to avoid equity RBC treatment for any of these securities—particularly so close to year-end. We would be very appreciative if NAIC Staff and SAPWG would give serious consideration to our proposal, and we stand prepared to answer any questions or offer help, if needed.

Sincerely,

John Petchler

John Petchler, PPIA President, on behalf of the PPIA Board of Directors

CC: Ms. Julie Gann, Assistant Director—Solvency Policy

w:\national meetings\2021\spring\tf\app\sap\minutes\att d comment letters\2020 12 15 ppi response to int 20-10 on nonconforming ctl.docx
Interpretation of the Statutory Accounting Principles Working Group

INT 20-11: Extension of Ninety-Day Rule for the Impact of 2020 Hurricanes, California Wildfires and Iowa Windstorms

INT 20-11 Dates Discussed

December 8, 2020; December 18, 2020

INT 20-11 References

SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers

INT 20-11 Issue

1. In the second half of 2020, the United States was impacted by several hurricanes in the Gulf Coast region, California Wildfires, and Iowa had a series of catastrophic straight-line windstorms. These events have resulted in loss of life and property, the extent to which is currently not known. State regulators and insurers are taking action to provide policyholders affected by these disasters with the support and understanding that is deserved.

2. This issue concerns consideration of allowing a fourth quarter 2020 temporary extension of the 90-day rule for uncollected premiums to insurers for policies in U.S. jurisdictions where a state of emergency was declared as identified below. This interpretation is intended to only cover impacted policies in areas for which a state of emergency has been declared by either the states, U.S. territories or federal government and which is noted on the Federal Emergency Management Agency (FEMA) website for the identified disasters as described below:

   a. Hurricane Isaias, Hurricane Laura, Hurricane Sally, Hurricane Delta, Hurricane Zeta and Hurricane Eta and the related tropical storms or flooding from these six named hurricanes.

   b. California Wildfires which were declared a disaster on or after August 1, 2020, some of which are ongoing during the fourth quarter 2020.

   c. Iowa straight-line windstorms impacted policies in the counties in which a state of disaster was declared in August 2020.

INT 20-11 Discussion

3. The Working Group reached a consensus for a one-time optional extension of the ninety-day rule for uncollected premium balances, bills receivable for premiums and amounts due from agents and policyholders required per SSAP No. 6, paragraph 9, as described within this paragraph.

   a. The exception applies to policies in effect as of the declaration of a state of emergency for the disasters described in paragraph 2.

   b. Insurers with policies in areas impacted by the disasters described in paragraph 2, which would be overdue by greater than ninety days (90) on December 31, 2020, may wait until February 28, 2021, before nonadmitting premiums receivable from those policies.

   c. Existing impairment analysis remains in effect for these affected policies.
4. The Working Group noted that a temporary sixty day (60) extension had previously been provided for other nationally significant disasters including INT 18-04: Extension of Ninety-Day Rule for the Impact of Hurricane Florence and Hurricane Michael; INT 17-01: Extension of Ninety-Day Rule for the Impact of Hurricane Harvey, Hurricane Irma and Hurricane Maria; INT 13-01: Extension of Ninety-Day Rule for the Impact of Hurricane/Superstorm Sandy; and INT 05-04: Extension of Ninety-day Rule for the Impact of Hurricane Katrina, Hurricane Rita and Hurricane Wilma. For this interpretation, as it encompasses a number of different disasters, the dates of emergency declarations vary. Therefore, for ease of application, the sixty-day extension applies to all uncollected premiums more than 90 days overdue from impacted policies at year-end 2020 and expires prior to the first quarter 2021 financial statements.

5. Due to the short-term nature of the applicability of this extension, which expires February 28, 2021, this interpretation will be publicly posted on the Statutory Accounting Principles (E) Working Group web page. This interpretation will be automatically nullified on March 1, 2021, and will be included as a nullified INT in Appendix H – Superseded SSAPs and Nullified Interpretations in the “As of March 2021” Accounting Practices and Procedures Manual.

INT 20-11 Status

6. No further discussion is planned.
Statutory Accounting Principles (E) Working Group
E-Vote
November 18, 2020

The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded Nov. 18, 2020. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Co-Vice Chair (IA); Richard Ford (AL); Kim Hudson (CA); William Arfanis (CT); Rylynn Brown (DE); Eric Moser (IL); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); David Smith (VA); and Amy Malm (WI).

1. Exposed INT 20-10T

The Working Group conducted an e-vote to consider exposure of Interpretation 20-10: Reporting Nonconforming Credit Tenant Loans (INT 20-10). This tentative interpretation clarifies the action from the Working Group’s Nov. 12 meeting, which permits continued Schedule D-1: Long-Term Bond reporting for nonconforming credit tenant loans (CTLs) if the reporting entity obtains a Securities Valuation Office (SVO)-assigned NAIC designation. (As a nonconforming CTL, the instrument does not qualify for Schedule D-1 reporting in accordance with the legal and structural requirements detailed in the Purposes and Procedures Manual of the NAIC Investment Analysis Office [P&P Manual].) This temporary provision provides an exception to the NAIC Policy Statement on Coordination of the Accounting Practices and Procedures Manual (AP&P Manual) and the P&P Manual, which is explicit that an NAIC designation from a credit analysis (and not a structural assessment) does not change an investment’s applicable Statement of Statutory Accounting Principles (SSAP) or reporting schedule. In addition to clarifying that nonconforming CTLs that had previously been reported on Schedule D-1 can continue this reporting with an SVO-assigned designation, the interpretation also specifies that nonconforming CTLs that had previously been reported on a different reporting schedule shall continue to report on the prior reporting schedule. As such, there is no requirement for reporting entities to pursue SVO-assigned designations for those CTLs.

This tentative interpretation is applicable for the year-end 2020 statutory financial statements and through the first three quarters of 2021 (expiring on Oct. 1, 2021). This time frame was provided to allow for continued discussion of the Schedule D-1 project, with the Working Group determining the appropriate reporting schedule for nonconforming CTLs. It is highlighted that all reporting entities shall be prepared to make adjustments to comply with the reporting schedule concluded by the Working Group as the appropriate reporting location for nonconforming CTLs.

Mr. Clark made a motion, seconded by Mr. Arfanis, to expose INT 20-10T for a public comment period ending Dec. 4, 2020. The motion passed unanimously.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded Dec. 8, 2020. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Co-Vice Chair (IA); Richard Ford (AL); Kim Hudson (CA); William Arfanis (CT); Rylynn Brown (DE); Eric Moser (IL); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); David Smith (VA); and Amy Malm (WI).

1. **Exposed INT 20-11**

The Working Group conducted an e-vote to consider exposure of *Interpretation 20-11: Extension of Ninety-Day Rule for the Impact of 2020 Hurricanes, California Wildfires and Iowa Windstorms* (INT 20-11). This tentative interpretation provides a 60-day extension from the 90-day rule for uncollected premium balances, bills receivable, and amounts due from agents and for policies directly affected by the noted 2020 hurricanes, California wildfires and Iowa windstorms. This temporary relaxation of the 90-day rule for directly affected policies is similar to previous extensions that have been granted for other major national storms and hurricanes.

For this interpretation, as it encompasses a number of different disasters, the dates of emergency declarations vary. Therefore, for ease of application, the 60-day extension applies to uncollected premiums more than 90 days overdue from affected policies at year-end 2020, and it expires prior to the first quarter of 2021 financial statements on Feb. 28, 2021.

Mr. Guerin made a motion, seconded by Mr. Clark, to expose INT 20-11. The motion passed unanimously.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
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This is one of my final letters as the Montana Insurance Commissioner as my fellow Montanans have honored me with the privilege of representing them in the United States House of Representatives. I will continue to champion our state-based system of insurance regulation while I am a member of Congress.

With that noted, I do have a concern as I close out my term as Insurance Commissioner: the proposed changes to the SSAP 71. There is no reason to change the current SSAP 71 accounting principle. There has been no policyholder peril, fraud, or company financial impairment by using SSAP 71 as currently allowed since 1998.

I believe the changes being proposed constitute a significant change in application of this statutory accounting principle and therefore should be deemed a substantive change under the SSAP guidelines. The Statutory Accounting Principles Working Group (SAPWG) continues to conclude that the proposed changes simply clarify the intent of the working group, but the proposed changes would significantly change the way some companies report certain commission arrangements. These companies have been reporting these arrangements the same way for decades without, as far as I have been informed, any harm to policyholders.

Efforts to fix something that isn't broken often have negative consequences, whether intentional or not. As a former state legislator and as an incoming federal legislator, I have always been a strong proponent for closely following appropriate processes and not taking shortcuts.

I encourage the SAPWG to take the necessary steps to study this issue further and give proposed substantive changes the appropriate attention they deserve.

Sincerely,

Matt Rosendale
January 22, 2021

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Items Exposed for Comment by the Statutory Accounting Principles Working Group on November 12, 2020 with Comments due January 22, 2021

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the exposure drafts released for comment by the NAIC Statutory Accounting Principles (E) Working Group (the Working Group). We offer the following comments:

**INT 20-03: Troubled Debt Restructuring Due to COVID-19**

This interpretation was effective for the specific purpose to address loan modifications in response to COVID-19. Consistent with the CARES act, this interpretation was only applicable for the term of the loan modification, but solely with respect to any modification, including a forbearance arrangement, interest rate modification, a repayment plan and other similar arrangement that defer or delays the payment of principal or interest for a loan that was not more than 30 days past due as of December 31, 2019. As determined in the CARES Act, this interpretation was originally only applicable for the period beginning on March 1, 2020 and ending on the earlier of December 31, 2020, or the date that was 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID–19) outbreak declared by the President on March 13, 2020 under the National Emergencies Act (50 U.S.C. 1601 et seq.) terminates.

On December 27, 2020, President Trump signed into law the *Consolidated Appropriations Act, 2021*, which slightly modified and extended the original CARES Act. These modifications included extending the provisions for temporary relief from troubled debt restructurings. Accordingly, on January 6, 2021, the provisions in this INT were tentatively extended to be applicable through the earlier of January 1, 2022 or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID–19) outbreak declared by the President on March 13, 2020 under the National Emergencies Act terminates. With this extension, this INT’s effective date corresponds with the current effective dates of the CARES Act. Unless the outbreak under the National Emergencies Act terminates, this INT will automatically expire on January 2, 2022 (to include year-end 2021 financial statements reporting).

Interested parties support the continued consistency with the Cares Act.
INT 20-07: Troubled Debt Restructuring of Certain Debt Investments Due to COVID-19

This interpretation was originally effective for the specific purpose to provide practical expedients in assessing whether modifications in response to COVID-19 are insignificant under SSAP No. 36 and in assessing whether a change is substantive under SSAP No. 103R. This interpretation will only be applicable for the period beginning on March 1, 2020 and ending on the earlier of December 31, 2020, or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID–19) outbreak declared by the President on March 13, 2020 under the National Emergencies Act (50 U.S.C. 1601 et seq.) terminates. For clarity, this effective timeframe specifies when modifications in response to COVID-19 can be incorporated using the provisions of this interpretation. Once incorporated, the provisions of this interpretation will continue for the duration of the modification.

On December 27, 2020, President Trump signed into law the Consolidated Appropriations Act, 2021, which slightly modified and extended the original CARES Act. These modifications included extending the provisions for temporary relief from troubled debt restructurings. Accordingly, on January 6, 2021, the provisions in this INT were tentatively extended to be applicable through the earlier of January 1, 2022 or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID–19), outbreak declared by the President on March 13, 2020 under the National Emergencies Act terminates. With this extension, this INT’s effective date corresponds with the current effective dates of the CARES Act. Unless the outbreak under the National Emergencies Act terminates, this INT will automatically expire on January 2, 2022 (to include year-end 2021 financial statements reporting).

Interested parties support the continued consistency with the Cares Act.

Ref #2019-24: Levelized and Persistency Commission

On November 12, 2020, the Working Group held a hearing to receive comments and based on those comments, took the following actions:

- Re-exposed the prior version of SSAP #71 with certain edits: – (1) the proposed effective date of Jan.1, 2021 was changed to be effective upon adoption, and (2) the revised text made explicit that the proposed revisions will apply to contracts in effect as of the date of adoption.

- Determined that the revisions to SSAP #71 met the due process for either a substantive or a non-substantive revision but concluded to keep the revision classified as nonsubstantive. The Working Group reiterated that it is not the impact of a change on an individual entity that determines whether a change is substantive or non-substantive, but whether the revision is in line with the original intent of the SSAP. The Working group noted that this is a clarification of existing guidance consistent with original intent. (Commissioner Donelon noted an objection to the classification as non-substantive.)

- Directed NAIC Staff to draft an Issue Paper to document the discussion on this topic for historical purposes.

Interested parties would like to again thank the Working Group for the opportunity to continue to comment on the most recent revisions to exposure Ref #2019-24 – Levelized and Persistency Commission (SSAP No. 71, Policy Acquisition Costs and Commissions) discussed on November 12, 2020 (the “Exposure”).

These comments begin with industry comments regarding the Working Group’s most recent revisions to the Exposure:
Paragraph #5 new comments pertain to the sentence below:

Having a third party pay commission costs to the selling agent is strong evidence of a potential funding arrangement which shall be recognized as a liability because the substance of the arrangement indicates that repayment is reasonable and probable, even if a contingency has been incorporated into the funding arrangement, until unless the underlying policy has been cancelled.

The Working Group has made a change to the last phrase of this sentence that still does not provide clarity as to its meaning and to the sentence as a whole. Assuming that the phrase refers to the contingency noted in the previous phrase within the sentence, industry disagrees with wording that creates a blanket statement across all third-party agreements with regard to recognizing a liability similar to a funding agreement. During the entire exposure/revision process, interested parties has consistently stated that agreements which include traditional elements such as persistency as part of a legally binding commission contract should be excluded from the funding agreement treatment as was provided in the original (current) SSAP No. 71 wording. If the last phrase “until the underlying policy has been cancelled” pertains to the recognition of the liability, it seems that the wording does not contemplate even a partial repayment of the liability during the period when the policy is active.

Paragraph #7 new comments pertain to the following:

The nonsubstantive revisions adopted TBD date regarding levelized commission are to clarify the original intent of this statement and apply to existing contracts are effective in effect on the date of adoption of the revisions January 1, 2021.

Industry has consistently maintained that there has been a long-standing industry practice to link third party contracts to insurance elements such as persistency, including commission arrangements, reinsurance contracts, etc. Removing this link as has been indicated in the Working Group revisions is a substantive change. As such, we do not agree with the language in paragraph #7 that calls the revisions nonsubstantive and we disagree that such changes should be put in effect immediately upon adoption since they are substantive in nature and require further evaluation.

Certain of the third-party contracts noted above are complex and not quite as simple as the description of levelized commissions in the most recent draft of the Exposure. The Exposure depicts a simple arrangement whereby the insurer repays a third party over time, with interest, for making upfront heaped commissions to agents. This does not consider, for example, certain third-party contracts for which the insurer pays the third-party trail commissions based upon account value in-force in exchange for performing many contractual agency services other than simply funding and making upfront payments to selling agents. Such complex contracts require sufficient time to allow insurers to work with their state of domicile to determine the correct application of the revised guidance with respect to contracts which the regulator has already approved. Then, if establishment of a liability is indeed required, additional time would be necessary to calculate such an accrual and review with external auditors prior to reporting the change on a quarterly or annual statement. For these reasons, and as you suggested, Chairman Bruggeman, we propose that the revisions within the Exposure be adopted with an effective date no sooner than 12/31/21.

Comments previously made on existing revisions included for purposes of documentation:

Paragraph #4, most recent exposure:

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

Paragraph #4, most recent exposure with highlighted edits:
4. Levelized commissions occur in situations where agents receive normal (non-level) commissions with payments made by a third party. It is intended, but not necessarily guaranteed, that the amounts paid to the agents by the third party would ultimately be repaid (with interest explicit or implied) to the third party by levelized payments (which are less than the normal first year commissions but exceed the normal renewal commissions) from the reporting entity over time. (Note: levelized repayments made by the reporting entity extend the repayment period but might not be a straight-line repayment.) In instances where the levelized commission is not tied to, or contingent upon, traditional elements such as policy persistency or premium payments, these transactions are, in fact, funding agreements between a reporting entity and a third party, regardless of how the payment to the third party is characterized when the contract between the reporting entity and the third party has no substance but to defer commission payments by the reporting entity. The continuance of the stream of payments specified in the levelized commission contract in these situations is a mechanism which attempts to bypass recognition of those expenses which are ordinarily charged to expense in the first year of the contract. Consequently, the normal link between the persistency of the policy, the continuance of the premium payment or the maintenance of the agent's license with the reporting entity is not maintained with respect to the payment stream.

Industry proposes to replace a large section of paragraph #5, including the Working Group recent revisions, with more concise language that expresses the need to establish a liability when an arrangement is in substance a funding agreement. The current revisions are lengthy and somewhat redundant. Industry continues to disagree with the current revisions which too broadly state that all third-party arrangements, even those with traditional insurance elements, are considered funding arrangements. Industry retained the concept of the link between the accrual of commissions and traditional elements such as policy persistency.

Excerpt from paragraph #5, most recent exposure requested to be deleted:
Arrangements that use a third party to pay agents who write policies for the reporting entity and the insured can be an attempt to de-link the relationship between the insurer and those agents and defer or levelize the acquisition commissions. The insurance reporting entity is required to recognize the full amount of earned commission costs to the direct policy writing agents even if those costs are paid indirectly to the agents by a third party through the use of levelized commission, or similar arrangement, which is in substance a funding arrangement. Having a third party pay commission costs to the selling agent is strong evidence of a potential funding arrangement which shall be recognized as a liability because the substance of the arrangement indicates that repayment is reasonable and probable, even if a contingency has been incorporated into the funding arrangement, until the underlying policy has been cancelled. A third-party structure cannot recharacterize (e.g. by referencing policy persistency) and delay recognition of liabilities for initial sales commission owed from the writing of policies regardless of how a third-party arrangement is structured with regards to the timing of payment from the insurer. The amount owed for full initial sales commission shall be recognized immediately as the writing of an insurance contract is the event that obligates the insurer, and such action shall occur consistently among insurers. As such, this recognition is required regardless if the insurer owes a selling agent directly or if a third-party has been contracted to provide payment to the selling agent.

Interested parties highlighted wording to replace the above excerpt from paragraph #5:
The reporting entity is required to recognize the full repayment amount of earned commission costs by the direct policy writing agents even if those costs are paid indirectly by a third party through the use of levelized commission, or similar arrangement, which is in substance a funding arrangement. Recognition of those commission costs and recording a liability is required in such arrangements that are not linked to or contingent upon traditional elements. Such treatment shall occur consistently among insurers.
Summary:

Since its initial exposure in August 2019, industry has had concerns with the substantive nature of the proposed revisions and has consistently expressed these concerns.

- The last paragraph of the current SSAP No. 71 states: “The use of an arrangement where commission payments are not linked to traditional elements such as premium payments and policy persistency, but rather are linked to the repayment of an advance amount requires the establishment of a liability for the full amount of the unpaid principal and accrued interest which is payable to a third party related to levelized commissions.” This wording was revised to instead explicitly include arrangements linked to traditional elements with those that have no substance other than to link to the repayment of an advance amount. This is clearly a substantive change and not clarifying the original intent. It is a change to the intent.

- The current revisions require the accrual of a liability in situations that are inconsistent with the guidance SSAP No. 5R. Under a levelized commission program a third party has the obligation for the full initial sales commission. The insurer’s obligation under a levelized commission program that incorporates persistency should be accrued to the extent of legally contracted amounts owed. We do not believe the original intent of the SSAP required accruing for amounts that are not yet due and that may never be due. We strongly feel that the recognition of an obligation based on persistency is in accordance with the principles of SSAP 5R.

- The interpretation of SSAP No.71 that persistency is the obligating event for accrual of the levelized/persistency commissions is long standing industry practice that has been subject to both independent audits and state insurance department examinations without this interpretation being raised as an issue nor requiring adjustments to the companies’ financial statements.

- The current proposed language does not address the many varying product/distribution compensation arrangements in the industry and interested parties continue to believe this will cause unintended consequences.

- The existing SSAP No. 71 guidance is consistent in the application of persistency being part of the transfer of the risk(liability) to another party. If the lapse risk(persistency) is transferred to another party, the liability that the insurance company may have is also transferred to that party and the insurance company has no liability. Removing persistency as a factor in the accrual of commissions is a dangerous precedent. The differentiation between commissions based on real insurance risks versus payments based solely upon the passage of time in SSAP No. 71 goes directly to the risk transfer issue of one type of level commissions versus another. The proposed additional language eliminates this differentiation.

Conclusion:

Industry continues to maintain that the revisions exposed have changed the original intent of SSAP No. 71 and do not believe that they are nonsubstantive. Removing insurance elements from the determination of obligating events of third-party commission contracts may set a precedent that will have significant unintended consequences. As such, interested parties request that the Working Group consider these comments and proposed revisions. In addition, we request that this exposure be categorized as substantive, and given due process and an effective date.

Ref #2019-34: Related Parties, Disclaimers of Affiliation and Variable Interest Entities

The Working Group exposed this agenda item, with detailed revisions to SSAP No. 25, as detailed in a draft labeled with the date of November 12, 2020.
That draft contained proposed revisions intended to address the following key aspects:

- Clarify the identification of related parties and ensure that any related party identified under U.S. GAAP or SEC reporting requirements would be considered a related party under statutory accounting principles.

- Clarify that non-controlling ownership over 10% results in a related party classification regardless of any disclaimer of control or disclaimer of affiliation.

- Clarify the impact of a disclaimer of control or disclaimer of affiliate under SAP. As detailed, such disclaimers impact holding company group allocation and reporting as an SCA under SSAP No. 97, but do not eliminate the classification as a “related party” and the disclosure of material transactions as required under SSAP No. 25.

- Proposes rejection of several U.S. GAAP standards addressing variable interest entities.

On December 10, 2020, some members of interested parties and NAIC staff had a conference call to discuss the November 12th draft and possible edits to address concerns that the draft unintentionally impacted passive investments held by insurers in addition to investment in insurers. Staff amended the draft to address these concerns and is taking the updated draft back to the Working Group for its consideration.

Interested parties thank the staff for meeting with industry and in working to address our concerns.

Ref #2020-22: Accounting for Perpetual Bonds

The Working Group exposed revisions to SSAP No. 26R—Bonds to clarify that perpetual bonds are within scope as a “bond,” and shall apply the yield-to-worst concept. Additionally, perpetual bonds that do not possess or no longer possess a call feature shall follow fair value reporting.

Interested parties appreciated the opportunity to work directly with NAIC staff on this topic. After reviewing the modified proposal, we have one remaining comment, which has already been discussed with NAIC Staff. In paragraph 9, the proposal reads as follows:

“New Footnote: For perpetual bonds with an effective call option, any applicable premium shall be amortized to the next effective call date. For perpetual bonds purchased at a discount, any applicable discount shall be accreted utilizing the yield-to-worst concept.”

We recommend the language be “fine-tuned” as it implies those with a remaining premium would be amortized to the next effective call date. The language regarding amortization should be aligned with other bonds and reference the use of the yield to worst method, not the next effective call date. We suggest the following wording:

“New footnote: For perpetual bonds with an effective call option, any applicable premium shall be amortized utilizing the yield-to-worst method.”

Ref #2020-32: SSAP No. 26R - Disclosure Update

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 26R—Bonds to expand the called bond disclosures to also include bonds terminated early through a tender offer.

Interested parties have no comments on this item.
Ref #2020-33: SSAP No. 32R – Publicly Traded Preferred Stock Warrants

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 32R—Preferred Stock and SSAP No. 86—Derivatives to scope publicly traded preferred stock warrants into SSAP No. 32R with accounting at fair value.

Interested parties have no comments on this item.

Ref #2020-34: SSAP No. 43R – Government-Sponsored Enterprises – Credit Risk Transfer Transactions

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 43R—Loan-Backed and Structures Securities to incorporate minor scope modifications to reflect recent changes to the STACR and CAS programs. The proposed edits would allow credit risk transfer securities from Freddie Mac and Fannie Mae to remain in scope of SSAP No. 43R when a REMIC structure is used in the STACR program or CAS program.

Interested parties have no comments on this item.

Ref #2020-35: SSAP No. 97 – Audit Opinions

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed this agenda item with a request for comments on the extent in which situations exist that hinder admittance of 8.b.iii. entities due to the inability to quantify a departure from U.S. GAAP.

Interested parties is not aware of any situations that hinder admittance of 8.b.iii entities due to the departure of U.S. GAAP as a result of the inability to quantify the departure.

Ref #2020-37: Separate Account – Product Identifiers

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed the agenda item to solicit comments from state insurance regulators and industry regarding the degree of product identifying details needed to adequately assess the product features and reserve liabilities in the separate account. Particularly, this is requesting feedback on how to obtain increased product identifier reporting granularity in question 1.01 (product mix) of the separate account general interrogatories (GI 1.01). Additionally, feedback is requested regarding if a threshold should be established for when aggregate reporting would be permitted.

In response to the solicitation of feedback on additional product identifiers specifically for PRT and RILA transactions in the Separate Account General Interrogatories, the ACLI suggests adding a PRT and RILA product identifier. See example identifiers in bold:

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<tr>
<th>1 Product Identifier</th>
<th>Not Registered with SEC</th>
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<tr>
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<td>2 Private Placement</td>
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<td>3 Private Placement</td>
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<td>4 Other (Not PPVA or PPLI)</td>
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<td>Pension Risk Transfer Group Annuities</td>
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<td>All Other Group Annuities</td>
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<td>Registered Index Linked Annuities Individual Annuities</td>
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<td>All Other Individual Annuities</td>
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<td>Life Insurance</td>
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The addition of these identifiers would bifurcate out PRT and RILA transactions. Further, the use of these additional identifiers would show in General Interrogatory 1.01 if there were guarantees associated with these different products.

**Ref #2020-38: Pension Risk Transfer – Separate Account Disclosure**

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed the agenda item to solicit comments from state insurance regulators and industry regarding possible modifications to *SSAP No. 56—Separate Accounts* specific to pension risk transfer (PRT) products. Depending upon the feedback received, the Working Group would have several options available including, but not limited to, requiring the separate identification of pension risk transfer products (including transactions, guarantees, reserve assumptions, etc.) within existing disclosure requirements or the addition of a new general interrogatory (and perhaps new separate accounting reporting schedules / exhibits) to separate specific product detail that was previously reported in an aggregated format.

Pension risk transfer transactions differ from other separate account transactions in that PRT products are group products, not individual products. The American Council of Life Insurers believes that these differences are adequately addressed in the current disclosure requirements of SSAP No. 56 – Separate Accounts. Specifically, paragraphs 31c and 33a include disclosure requirements for products with guarantees, which may include PRT transactions. Further, these disclosure requirements extend to the General Account Annual Statement Note 35B. Additionally, the proposal above on Ref# 2020-37 will provide additional detail for PRT products in the General Interrogatories.

We believe that the current disclosures sufficiently capture PRT transactions however, we defer to the Working Group and regulators if these groups voice concern that they are not able to discern something specific.

**Ref #2020-39: Interpretation Policy Statement Updates**

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to *NAIC Policy Statement on Maintenance of Statutory Accounting Principles* in Appendix F—Policy Statements regarding the issuance and adoption of accounting interpretations.

Based upon interested parties’ discussion with NAIC staff and our understanding of the objective of the changes to *NAIC Policy Statement on Maintenance of Statutory Accounting Principles* in Appendix F—Policy Statements (Appendix F), we’ve marked up Appendix F with edits that clarify the policy for issuing interpretations which amend, supersede, or conflict with existing SSAPs (please see attached). Specifically, the interested parties’ proposed revisions clarify that such interpretations are temporary and restricted to circumstances requiring immediate, temporary guidance such as catastrophes or other emergencies. We believe the marked Appendix F is consistent with the intent to use interpretations in limited circumstances. Our proposed revisions explicitly establish that interpretations are not intended as a shortcut to bypass the deliberative process for amending existing statutory accounting guidance or developing new guidance.

**Ref #2020-40: Clarification of Prescribed Practices**

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed proposed revisions to the Preamble Implementation Questions and Answers to clarify prescribed practices. These revisions clarify that while any state in which a company is licensed can issue prescribed practices, the prescribed practices directed by the domiciliary state shall be reflected in the financial statements filed with the NAIC and are the financial statements subject to the independent audit requirements.

Interested parties are concerned that the discussion of prescribed and permitted practices in this proposal are likely to cause confusion. An insurer’s annual and quarterly statutory statements that are filed with the state of domicile
and all states the insurer is licensed are prepared in accordance with the accounting practices prescribed or permitted by the state of domicile. However, in addition to the financial statements required by the domiciliary state, a non-domiciliary state in which the company is licensed may require an insurer to file supplemental financial information that require or allow the use of different accounting practices in the supplementary filing than provided in the AP&P manual. We believe the proposal should be amended to clarify that if a non-domiciliary state in which the company is licensed requires or allows a practice by state statute / bulletin (or other state-wide provision) in such supplemental financial information that is different from NAIC SAP, that practice(s) is also considered a prescribed practice. We recommend changes to the proposed wording to clarify these points (please see attached).

Ref #2020-41: ASU 2020-06 - Convertible Instruments

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets, SSAP No. 72—Surplus and Quasi-Reorganizations and SSAP No. 86—Derivatives, to reject ASU 2020-06, Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40), Accounting for Convertible Instruments and Contracts in an Entity’s Own Equity for statutory accounting.

Interested parties have no comment on this item.

Ref #2020-42: ASU 2020-07 - Presentation and Disclosures by Not-for-Profit Entities

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2020-07, Not-for-Profit Entities (Topic 958), Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets as not applicable to statutory accounting.

Interested parties have no comment on this item.

* * *

Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell

Rose Albrizio

cc: NAIC staff

Interested parties

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Issue: Interpretation Policy Statement Updates

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Description of Issue: This agenda item proposes edits to Appendix F of the *NAIC Policy Statement on Maintenance of Statutory Accounting Principles*, clarifying the requirements regarding the issuance and adoption of accounting interpretations.

Existing Authoritative Literature:

*NAIC Policy Statement on Maintenance of Statutory Accounting Principles* (Appendix F) documents the requirements of interpretation issuances and adoptions.

Development of Interpretations to SSAPs and Referencing Interpretations Within SSAPs

9. Interpretations will be developed to address, but will not be limited to issues requiring timely application or clarification of existing SAP, which shall not amend, supersede or conflict with existing, effective SSAPs. Issues being considered as an interpretation must be discussed at no less than two open meetings. (Original introduction of the issue when the Working Group identifies the intent to address the issue as an "interpretation" during a public discussion is considered the first open meeting discussion.) The process must allow opportunity for interested parties to provide comments, but as interpretations are intended to provide timely responses to questions of application or interpretation and clarification of guidance, no minimum exposure timeframe is required.

10. The voting requirement to adopt an interpretation is a simple majority. As interpretations do not amend, supersede or conflict with existing SSAP guidance, the interpretation is effective upon Working Group adoption unless specifically stated otherwise. The Working Group shall report the adopted interpretation to the Task Force as part of its public report during the next NAIC national meeting (or earlier if applicable). Interpretations can be overturned, amended or deferred only by a two-thirds majority of the Task Force membership.

11. In rare circumstances, the Working Group may adopt an interpretation which creates new SAP or conflicts with existing SSAPs. Historically, these interpretations temporarily modified statutory accounting principles and/or specific disclosures were developed in response to nationally significant events (e.g., Hurricane Sandy, September 11, 2001). In order to adopt an interpretation that creates new SAP or conflicts with existing SSAPs, the Working Group must have 67% of its members voting (10 out of 15 members) with a super majority (7 out of 10, 8 out of 11 or 12, 9 out of 13, 10 out of 14, or 11 out of 15) supporting adoption. These interpretations can be adopted, overturned, amended or deferred only by a two-thirds majority of the Task Force membership.
12. As new SSAPs are developed, it is essential to review and, if necessary, update the status of interpretations related to SSAPs that are being replaced and/or new SSAPs being developed. The following options are available to the Working Group when a SSAP with existing interpretations is replaced:

a. **Interpretation of the new SSAP** - If the Working Group would like to maintain the interpretation, the new SSAP can be added to the list of statements interpreted by the interpretation. In addition, the status section of the new SSAP will list the interpretation number next to the heading “Interpreted by.”

b. **Nullification** - When an interpretation is nullified by a subsequent SSAP or superseded by another interpretation, the interpretation is deemed no longer technically helpful, is shaded and moved to Appendix H (Superseded SSAPs and Nullified Interpretations), and the reason for the change is noted beneath the interpretation title. The status section of the SSAP describes the impact of the new guidance and the effect on the interpretation (for example, nullifies, incorporated in the new SSAP with paragraph reference, etc.).

c. **Incorporation** - When an interpretation is incorporated into a new SSAP, the Working Group can choose from the following two options:

i. If the interpretation only interprets one SSAP, then the interpretation is listed as being nullified under the “affects” section of the SSAP and is not referenced under the “interpreted by” section of the status page of the SSAP.

ii. If the interpretation references additional SSAPs, and the Working Group intends to maintain the guidance, the interpretation is unchanged (no nullification). The new SSAP (Summary of Issue section) reflects that the interpretation issue has been incorporated into the new statement.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):** None

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:** None

**Convergence with International Financial Reporting Standards (IFRS):** N/A

**Staff Recommendation:** NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose clarifying revisions to *NAIC Policy Statement on Maintenance of Statutory Accounting Principles* in Appendix F regarding the issuance and adoption of accounting interpretations.

**Development of Interpretations to SSAPs and Referencing Interpretations Within SSAPs**

**Interpretations which DO NOT amend, supersede, or conflict with existing SSAPs**

9. Interpretations **will** be developed to address, **but will not be limited to** issues requiring timely application or clarification of existing SAP, which shall not amend, supersede or conflict with existing, effective SSAPs. Issues being considered as an interpretation must be discussed at no less than two open meetings. (Original introduction of the issue when the Working Group identifies the intent to address the issue as an “interpretation” during a public discussion is considered the first open meeting discussion.) The process must allow opportunity for interested parties to provide comments, but as interpretations are intended to provide timely responses to questions of application or interpretation and clarification of guidance, no minimum exposure timeframe is required.
10. **The voting requirement to adopt an interpretation is a simple majority.** As these interpretations do not amend, supersede or conflict with existing SSAP guidance, the interpretation is effective upon Working Group adoption, unless specifically stated otherwise. **The voting requirement to adopt an interpretation of this type is a simple majority.** The Working Group shall report the adopted interpretation to the Accounting Practice and Procedures (E) Task Force as part of its public report during the next NAIC national meeting (or earlier if applicable). Interpretations can be overturned, amended or deferred only by a two-thirds majority of the Task Force membership. For clarification, a two-thirds majority of the Task Force requires two-thirds of the entire Task Force membership, not just those electing to vote. Additionally, interpretations can be overturned, amended, deferred, or referred to either the Task Force and/or the Working Group by a simple majority of the Financial Condition (E) Committee.

**Interpretations which amend, supersede, or conflict with existing SSAPs**

11. **In rare certain circumstances such as catastrophes or emergencies requiring immediate, temporary statutory accounting guidance,** the Working Group may adopt an interpretation which creates a new SAP or conflicts with existing SSAPs. Historically, these interpretations temporarily modified statutory accounting principles and/or specific disclosures were developed in response to nationally significant events (e.g., Hurricane Sandy, September 11, 2001). **Interpretations that conflict with existing SSAPs shall be temporary guidance and restricted to circumstances arising from the need to issue guidance for circumstances requiring immediate temporary guidance.** In order to adopt an interpretation that creates new SAP or conflicts with existing SSAPs, the Working Group must have 67% of its members voting (10 out of 15 members) with a super majority (7 out of 10, 8 out of 11 or 12, 9 out of 13, 10 out of 14, or 11 out of 15) supporting adoption.

a. **These interpretations are effective upon Working Group adoption, unless stated otherwise, and shall be reported to the Accounting Practice and Procedures (E) Task Force as part of its public report during the next NAIC national meeting (or earlier if applicable).** In circumstance where the Working Group adopts an interpretation (which creates new SAP or conflicts with existing SSAPs) that is controversial in nature (i.e., due to regulator or industry feedback or could have a policy level impact), the Working Group may elect to postpone the effective date until the item has been discussed by the Task Force and the Financial Condition (E) Committee and both have had an opportunity to review the interpretation.

b. **These interpretations can be adopted overturned, amended or deferred by a two-thirds majority of the Task Force membership.** For clarification, a two-thirds majority of the Task Force requires two-thirds of entire Task Force membership, not just those electing to vote. Additionally, interpretations can be overturned, amended, deferred, or referred to either the Task Force and/or the Working Group by a simple majority of the Financial Condition (E) Committee.

Staff Review Completed by: Jim Pinegar, NAIC Staff – August 2020

**Status:**
On November 12, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to *NAIC Policy Statement on Maintenance of Statutory Accounting Principles* in Appendix F—Policy Statements regarding the issuance and adoption of accounting interpretations, as illustrated above.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Clarification of Prescribed Practices

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Description of Issue:
This agenda item intends to clarify the definition and application of prescribed practices. This issue has been presented in response to questions received on existing references in the NAIC Accounting Practices & Procedures Manual (AP&P). In summary:

- Each state insurance department has the authority to regulate any insurance company that is licensed in their state. The AP&P Manual is not intended to preempt states’ legislative and regulatory authority.

- The financial statements filed with the NAIC and subject to independent audit, pursuant to Model Law 205: Annual Financial Reporting Model Regulation shall be in accordance with practices prescribed or permitted by the domiciliary state.

- However, in addition to the financial statements required by the domiciliary state, a non-domiciliary state in which the company is licensed may require an insurer to file supplemental financial information that require or allow the use of different accounting practices in the supplementary filing than provided in the AP&P manual. Ideally, to prevent reporting entities from having to file different financial statements or reports prepared on different basis of accounting with differenting states, the practices permitted or prescribed by a domiciliary state will be accepted in all states in which a company is licensed. However, as noted above, the provisions of the AP&P Manual are not intended to preempt states’ legislative or regulatory authority. Accordingly, each state in which a company is licensed could require supplemental financial information that requires or allows statutory accounting practices that differ from the AP&P manual. If a non-domiciliary state in which the company is licensed requires or allows a practice by state statute / bulletin (or other state-wide provision) in such supplemental financial information that is different from NAIC SAP, that practice(s) is also considered a prescribed practice. If the company files supplemental financial information that reflect this practice(s), even if the supplemental financial information is filed only in the non-domiciliary state, then the prescribed practice disclosure of Note 1 shall apply.

Examples of two possible situations:

Scenario 1: Non-domiciliary State A issues a state statute / bulletin that requires the filing of supplemental financial information and which requires the use of a prescribed accounting practice for all companies that are licensed and doing business within State A. Domiciliary State B does not issue a comparable state statute / bulletin.

Scenario 1 Conclusion: The reporting entity shall file statutory financial statements with their domiciliary state and the NAIC in accordance with the statutory accounting practices permitted or prescribed by the domiciliary state (State B). (These financial statements would be subject to the
independent audit requirements per Model 205.) The reporting entity also shall file separate supplemental financial information with State A in accordance with the accounting practice mandated by that non-domiciliary state but shall include the prescribed practice disclosure of Note 1 in the supplemental financial information.

**Scenario 2:** Non-domiciliary State A issues a state statute / bulletin that allows an accounting practice for all companies that are licensed and doing business within State A. Domiciliary State B does not issue a comparable state statute / bulletin.

**Scenario 2 Conclusion:** The reporting entity shall file statutory financial statements with their domiciliary state and the NAIC in accordance with the statutory accounting practices permitted or prescribed by the domiciliary state (State B). (These financial statements would be subject to the independent audit requirements per Model 205.) The reporting entity then has the ability, but is not required, to file supplemental financial information in State A that reflects the accounting practice prescribed by that non-domiciliary state and shall include the prescribed practice disclosure of Note 1 in the supplemental financial information.

**Existing Authoritative Literature:**

**Preamble**

12. Codification is not intended to preempt state legislative and regulatory authority. While Codification is expected to be the foundation of a state’s statutory accounting practices, it may be subject to modification by practices prescribed or permitted by a state’s insurance commissioner. Statutory financial statements will continue to be prepared on the basis of accounting practices prescribed or permitted by the states. As a result, in 1998 the AICPA's Insurance Companies Committee determined that it will not be necessary for the Auditing Standards Board to grant the Codification status as an OCBOA since it will not be the sole basis for preparing statutory financial statements. Further, auditors will be permitted to continue to provide audit opinions on practices prescribed or permitted by the insurance department of the state of domicile.

**Preamble Questions and Answers**

**Permitted Practices Advance Notification Requirement – Implementation Questions and Answers**

2. **Q:** What is the difference between a permitted accounting practice and a prescribed practice?

   **A:** **Permitted** accounting practices include practices specifically requested by an insurer that depart from NAIC Statutory Accounting Principles (SAP) and state prescribed accounting practices, as described below, and have received approval from the insurer’s domiciliary state regulatory authority.

   **Prescribed** accounting practices are those practices that are incorporated directly or by reference by state laws, regulations and general administrative rules applicable to all insurance enterprises domiciled in a particular state. The NAIC AP&P Manual is not intended to preempt states’ legislative and regulatory authority.

   If a reporting entity requests an accounting practice that differs from state prescribed accounting practices, but is in accordance with NAIC SAP, advance notice of approval is not required.

**The NAIC Model laws do not contain a definition of “prescribed practice,” but references to prescribed practices are noted in the Model laws below. These are provided as reference. There are no revisions proposed to the Model Laws:**

© 2021 National Association of Insurance Commissioners
Model 205 – Annual Financial Reporting Model Regulation

Section 6 - Designation of Independent Certified Public Accountant

B. The insurer shall obtain a letter from the accountant, and file a copy with the commissioner stating that the accountant is aware of the provisions of the insurance code and the regulations of the Insurance Department of the state of domicile that relate to accounting and financial matters and affirming that the accountant will express his or her opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that Insurance Department, specifying such exceptions as he or she may believe appropriate.

Model 450 – Insurance Holding Company System Model Regulation with Reporting Forms and Instructions

Item 12. Financial Statements and Exhibits

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of the person filed with the insurance department of the person’s domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of the state.

Model 785 – Credit for Reinsurance Model Law

Section 4. Qualified U.S. Financial Institutions

4.c. Maintains at least $250 million in capital and surplus when determined in accordance with the NAIC Accounting Practices and Procedures Manual, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices; and is

Model 787 – Term and Universal Life Insurance Reserve Financing Model Regulation

Section 6. The Actuarial Method

B. Valuation used for Purposes of Calculations

For the purposes of both calculating the Required Level of Primary Security pursuant to the Actuarial Method and determining the amount of Primary Security and Other Security, as applicable, held by or on behalf of the ceding insurer, the following shall apply: (1) For assets, including any such assets held in trust, that would be admitted under the NAIC Accounting Practices and Procedures Manual if they were held by the ceding insurer, the valuations are to be determined according to statutory accounting procedures as if such assets were held in the ceding insurer’s general account and without taking into consideration the effect of any prescribed or permitted practices; and

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None
Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None


Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose proposed revisions to the Preamble Implementation Questions and Answers to clarify prescribed practices. These revisions clarify that while any state in which a company is licensed can issue prescribed practices, the prescribed practices directed by the domiciliary state shall be reflected in the financial statements filed with the NAIC and are the financial statements subject to the independent auditor requirements. (NAIC staff do not believe revisions are necessary to paragraph 12 of the Preamble as that guidance does not limit practices to the domiciliary state and already confirms that the domiciliary state practices shall be reflected in the financial statements subject to audit. For reference paragraph 12 is below.)

12. Codification is not intended to preempt state legislative and regulatory authority. While Codification is expected to be the foundation of a state’s statutory accounting practices, it may be subject to modification by practices prescribed or permitted by a state’s insurance commissioner. Statutory financial statements will continue to be prepared on the basis of accounting practices prescribed or permitted by the states. As a result, in 1998 the AICPA’s Insurance Companies Committee determined that it will not be necessary for the Auditing Standards Board to grant the Codification status as an OCBOA since it will not be the sole basis for preparing statutory financial statements. Further, auditors will be permitted to continue to provide audit opinions on practices prescribed or permitted by the insurance department of the state of domicile.

Proposed Revisions to the Preamble Questions and Answers:

2. Q: What is the difference between a permitted accounting practice and a prescribed practice?

A: Permitted accounting practices include practices specifically requested by an insurer that depart from NAIC Statutory Accounting Principles (SAP) and state prescribed accounting practices, as described below, and have received approval from the insurer’s domiciliary state regulatory authority.

Prescribed accounting practices are those practices that are incorporated directly or by reference by state laws, regulations and general administrative rules applicable to all insurance enterprises domiciled and/or licensed in a particular state. The NAIC AP&P Manual is not intended to preempt states’ legislative and regulatory authority. Prescribed accounting practices of the domiciliary state shall be reflected in the statutory financial statements filed with the NAIC. Non-domiciliary states may additionally require insurance entities licensed in their state to file supplementary financial information that requires or allows the use of different accounting practices in the supplementary filing than provided in the AP&P manual.

If a reporting entity requests an accounting practice that differs from state prescribed accounting practices, but is in accordance with NAIC SAP, advance notice of approval is not required.

Staff Review Completed by:
Julie Gann - NAIC Staff
July 2020
Status:
On November 12, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed proposed revisions to the Preamble Implementation Questions and Answers to clarify prescribed practices, as illustrated above. These revisions clarify that while any state in which a company is licensed can issue prescribed practices, the prescribed practices directed by the domiciliary state shall be reflected in the financial statements filed with the NAIC and are the financial statements subject to the independent audit requirements.

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Statutory Accounting Principles (E) Working Group

We have reviewed the revised proposed changes to SSAP No. 71 – Policy Acquisition Costs and Commissions as outlined in Ref. #2019-24. We continue to question several elements of the proposal and strongly object to the revisions for the following reasons:

1. This continues to be a substantive change to existing policy, contrary to the characterization in the published exposure draft.
2. The proposal continues to alter the fundamental premise of statutory accounting by creating a situation in which certain historically period expenses, trail commission payments, are to be treated differently from other period expenses by way of an accrual methodology, which leads to:
   a. A hybrid of statutory, GAAP and tax accounting.
   b. Fundamentally and permanently different economics for products designed with trail commission payments, leading to the need for significant effort at primary writers to redesign and/or reprice such products, presumably at a cost to the consumer.
   c. Guaranteed renewable products, like Long Term Care Insurance, could be exposed to further rate increases if the fundamental profit dynamics of the products change as a result of the new reserving practices.
   d. New uncertainty within the statutory accounting framework as to which other period expenses should also be accrued or might be targeted for similar treatment.
   e. A situation whereby trail commission expenses have a greater impact on statutory capital than other, similar expenses.
   f. A disincentive for primary writers to align the interests of the writer, broker/agent and policyholder through trail commissions because of the unique treatment and resulting capital implications.
3. Should the proposed changes be adopted, primary writers will be exposed to new and substantial accounting and actuarial workload relating to the determination of accrual methodologies for each affected product and the related periodic ‘true-up’ required to adjust the new statutory reserves for actual performance.
4. There is no apparent benefit for the consumer, primary writer, investment community, or regulatory bodies. The additional costs involved are highly restrictive and will likely cause either a decline in product offering or result in a higher cost to the consumer, which will ultimately curb the ability for the average person to save some of their earnings for retirement, children’s schooling or other reason.
5. Moreover, there will be a material adverse impact on the RBC ratios of carriers utilizing legitimate third-party distribution structures, which may in some cases be material enough to affect carrier capital solvency.
We understand some have expressed concerns that related party structures have been put in place to achieve a deferral of commission expense, and understand that in such circumstances existing accounting rules may appropriately require that a liability should be established - but we continue to be of the view that existing accounting standards provide both the necessary guidance and basis for enforcement. In cases – like Acadia’s carrier contracts - where a third-party licensed agent is involved and applies a trail commission to in-force policies only, there is no obligation to pay commissions until the anniversary date of the policy and therefore no reason to recognise a liability. The proposed change ignores both of these material elements – the involvement of a third party, and fact that an obligation does not arise until the anniversary date – and sweeps up these materially different arrangements in the same basket as related-party structures.

It is manifestly contrary to the public interest to pursue a change where:

- there is no clear benefit or public interest in favour of it;
- there is ample clarity and scope under existing accounting rules;
- there is material adverse impact on carriers;
- there is resulting adverse impact on the public through higher prices, reduced access, or both.

We urge the NAIC to reject this poorly conceived and clearly material change which is rife with unintended consequences, and instead rely on the proven ample scope under the existing SSAP 71 which has been in effect for decades.

cc: Julie Gann (jgann@naic.org), Robin Marcotte (rmarcotte@naic.org), Jim Pinegar (jpinegar@naic.org), Fatima Sediqzad (fsediqzad@naic.org), Jake Stultz (jstultz@naic.org)
Wayne Goodwin  
former NC Insurance Commissioner (2009-2016)  
8306 Wycombe Lane, Raleigh NC 27615  
Email gwaynegoodwin@gmail.com

To: Dale Bruggeman, Chair  
Statutory Accounting Principles (E) Working Group National  
Association of Insurance Commissioners (NAIC)

From: Hon. Wayne Goodwin, former NC Insurance Commissioner Date:  
January 19, 2021

Re: Comment Period / Revised Proposed Changes to SSAP No. 71 – Policy Acquisition Costs and Commissions

It has come to my attention that the Statutory Accounting Principles (E) Working Group is accepting comments pertaining to the Revised Proposed Changes to SSAP No. 71 – Policy Acquisition Costs and Commissions.

Although I concluded my service as NC Insurance Commissioner four years ago, I served eight (8) years in that office and an additional four (4) years as Assistant Commissioner, for a total of 12 years as a state insurance regulator. During that time, I also served on the NAIC Executive Committee and as Vice Chair of the Southeast Zone. Further, I have experience both as a state legislator (8 years) and licensed attorney (28 years). To the best of my ability, I have remained aware of many contemporary issues, proposals, and agenda items before the NAIC and its various committees and working groups.

Before the comment period closes, I want to restate the compass points of my tenure as well as that of my predecessor, the late great Jim Long: (1) Consumer protection and (2) fair, stable, reasonable regulation of the insurance market. Paramount, first and foremost of course, is consumer protection.

Today I submit my comment in opposition to the revised proposed changes to SSAP No. 71 based on the following:

SSAP 71 has been in place approximately 30 years and, by most accounts of which I am familiar, it has worked well.

It is my understanding that during those three decades such levelized commission programs have gone through multiple official examinations by insurance regulators with few to no material issues having been noted.

To the best of my knowledge presently, there has been no policyholder peril, fraud, or company financial impairment by using the current version of SSAP 71. Accordingly, existing rules have apparently worked as intended.

The revised changes have been described as non-substantive but upon analysis by other current and past state insurance regulators whom I respect and trust, whose comments in opposition or expressing concern are incorporated by reference, and upon my own review, it is more evident that the proposal is,
in fact, substantive – in part because the current proposal will apparently cause unnecessary financial damage to some carriers and their policyholders because rating agencies would consequently and unnecessarily downgrade any impacted company due to a retroactive drop in surplus/RBC numbers.

Among other consumer concerns is this: This proposed new reserving practice could cause further, unnecessary rate increases for guaranteed renewable products like Long Term Care insurance.

Respectfully, acknowledging the above and consumer protection most of all, it appears that a more detailed, comprehensive study is necessary before further consideration of the revised proposal. More feedback will be particularly enlightening and will provide the best counsel on what direction – if any -- to take on the proposal.

# # #

c: Julie Gann (jgann@naic.org), Robin Marcotte (rmarcotte@naic.org), Jim Pinegar (jpinegar@naic.org), Fatima Sediqzad (fsediqzad@naic.org), Jake Stultz (jstultz@naic.org)
January 22, 2021

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Ref #2019-24 Levelized and Persistency Commission

Dear Mr. Bruggeman,

Guggenheim Life and Annuity Company is writing to express our concern with the proposed changes to SSAP No. 71 set forth in agenda item #2019-24: Levelized and Persistency Commission (“2019-24”). There have been serious flaws in the exposure process, including the designation of the proposed change as “nonsubstantive”, inconsistency regarding how to characterize the proposed changes, and a changing effective date.

Companies potentially impacted by 2019-24, in their attempt to provide input, have been aiming at a constantly moving target. 2019-24 has gone through several rounds of exposure, with significant variations to foundational aspects of the proposal, including how reporting entities should classify the proposed changes and the effective date of the proposed changes. The proposal has varied on the fundamental point of whether the change is a correction of error or change in accounting principle. Similarly, the effective date of the proposal has changed 3 times (from no effective date, to a January 1, 2021 effective date, to an “effective upon adoption” date).

We believe that a change to an accounting principle dating back to 1998 should be deemed a substantive change. The Statutory Accounting Principles Working Group has determined the process around 2019-24 has met the due process requirements of a substantive revision; however, we believe additional scrutiny and process should be given to this issue for several reasons. First, the proposed changes constitute a change to accounting principles that could have a significant impact on certain reporting entities. Second, decades of examinations and audits did not result in any objection to reporting entities’ reporting of the commission arrangements at issue.1 Third, companies have not harmed policyholders nor put themselves in financial impairment by reporting the way they have for decades. To us, this change in accounting principle seems like a punitive measure against a small number of companies that have been reporting these commissions a certain way for decades.

We appreciate the opportunity to comment on 2019-24 and believe regulators should continue to explore this issue and come to a reasonable solution.

Sincerely,

Ellyn M. Nettleton
Chief Accounting Officer

c: NAIC Staff

1 Note also that a 2010 SEC complaint against a carrier explained that levelized commissions were a common practice in the insurance industry. There is no evidence in the complaint that the statutory accounting treatment was ever determined not to be in accordance with statutory accounting principles.
December 7, 2020

Dale Bruggeman, Chair
NAIC Statutory Accounting Principles (E) Working Group

Re: SSAP No. 71 - Policy Acquisition Costs and Commissions

Dear Chair Bruggeman & Members of the Working Group:

I write to you today on behalf and at the request of the elected leadership of the National Council of Insurance Legislators (“NCOIL”)1 regarding the NAIC’s Statutory Accounting Principles Working Group’s (WG) efforts to update SSAP No. 71 titled “Policy Acquisition Costs and Commissions.” Without delving deeply into the specifics of the principle itself, with which you are well-versed, NCOIL has significant concerns about it. We note that SSAP No. 71 has been in effect since 1998, and inquire why, after 22 years, there needs to be a rush to implementation of this proposal for year-end?

Additionally, our members have heard differing opinions as to whether the proposed changes are substantive or non-substantive. Candidly, when NCOIL’s legislators start to hear of substantive changes being made via a handbook or manual, it creates tension because it brings to mind the debate surrounding incorporation by reference (IBR) for substantive matters. Beyond this impairment of the legislative prerogative, I must note that there is a constitutional provision in California stating that no law shall be enacted except by statute and no statute except by bill. Regardless of the determination on substantive vs non-substantive here though, there seems to be little debate that these changes could have a material and perhaps significant impact on insurers

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1 NCOIL is a national legislative organization with the nation’s 50 states as members, represented principally by legislators serving on their states’ insurance and financial institutions committees. NCOIL writes Model Laws in insurance and financial services, works to preserve the State jurisdiction over insurance as established by the McCarran-Ferguson Act seventy-five years ago, and to serve as an educational forum for public policymakers and interested parties. Founded in 1969, NCOIL works to assert the prerogative of legislators in making State policy when it comes to insurance and educate State legislators on current and longstanding insurance issues.
if adopted. If the impact is as large as some have told us, and we have heard of impacts as high as 30% of risk-based capital (RBC), it strikes NCOIL as quite bad timing to implement such changes as the entire global economy is suffering during this global pandemic. A number of companies from several states have advised us that the impact on their capital will be so great that these now-healthy companies would fall below the RBC regulatory action level if this change were to be implemented.

One of our most senior leaders has asked us, and we in turn ask you, if a solvent & healthy insurance carrier has been accounting for commissions in error due to a misunderstanding of SSAP No. 71, and the proposed change to SSAP No. 71 threatens to render that insurer insolvent, then is the proposed change really meeting its intent? It certainly would seem to fly in the face of the number one priority of the state regulatory system.

Accordingly, NCOIL requests and recommends that the WG delay implementation of the proposal until such time that staff completes the issue paper it is charged with drafting on the classification of the proposal. Moreover, NCOIL requests and recommends that in any case or at any point if the WG determines to move forward with the proposal, it be subject to a five year phase-in period in order to allow companies to maintain their health, soundness and solvency as the capital impact of the “clarification” to SSAP No. 71 takes effect.

On behalf of our member legislators, I thank you for your consideration of this matter.

Very truly yours,

Thomas B. Considine
Chief Executive Officer
NCOIL

cc:

The Honorable Matt Lehman
Indiana Representative
NCOIL President

The Honorable Ken Cooley
California Assemblyman
NCOIL Vice President

The Honorable Kevin Cahill
New York Assemblyman
NCOIL Treasurer

The Honorable Joe Fischer
Kentucky Representative
NCOIL Secretary

The Honorable Jason Rapert
Arkansas Senator
NCOIL Immediate Past President

The Honorable Travis Holdman
Indiana Senator
NCOIL Immediate Past President
Attachment One-F
Accounting Practices and Procedures (E) Task Force
3/23/21

The Honorable Ray Farmer
NAIC President
Director
South Carolina Department of Insurance

The Honorable David Altmaier
NAIC President-Elect
Commissioner
Florida Office of Insurance Regulation

The Honorable Dean Cameron
NAIC Vice President
Director
Idaho Department of Insurance

The Honorable Chlora Lindley-Myers
NAIC Secretary-Treasurer
Director
Missouri Department of Commerce and Insurance

The Honorable Mike Consedine
Chief Executive Officer
NAIC
February 24, 2021

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Ref #2020-36, Derivatives Hedging Fixed Indexed Products

Dear Mr. Bruggeman:

Interested parties would like to thank the Statutory Accounting Principles Working Group (SAPWG) for the opportunity to comment on the exposed 2020-36, Derivatives Hedging Fixed Indexed Products

The interested parties’ response will be brief at this time as we continue our work reviewing the exposure, assessing the proposal and working on potential variances to the exposure.

Interested parties are committed to working with NAIC staff and SAPWG on this very complicated and important topic.

*     *     *     *     *

If you have any questions in the interim, please do not hesitate to contact us

Sincerely,

D. Keith Bell Rose Albrizio

cc: Interested parties
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: SSAP No. 26R - Disclosure Update

Check (applicable entity):

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<th>P/C</th>
<th>Life</th>
<th>Health</th>
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Description of Issue: During the Summer National Meeting, through agenda item #2020-02: Accounting for Bond Tender Offers, the Working Group clarified that the accounting and reporting of investment income and capital gains/losses, due to early liquidation either through a call or a tender offer shall be similarly applied. This nonsubstantive update was effective on July 30; however, reporting entities that had historically applied a differing accounting methodology and required systems changes to properly account for the early termination of tendered bonds, were granted an effective date deferral of no later than January 1, 2021.

This agenda item is to expand an existing disclosure regarding called bonds to include tendered bond activity.

Existing Authoritative Literature: Only the relevant disclosures from SSAP No. 26R—Bonds, have been included below.

30. The financial statements shall include the following disclosures:

   i. For securities sold, redeemed or otherwise disposed as a result of a callable feature (including make-whole call provisions), disclose the number of CUSIPs sold, disposed or otherwise redeemed and the aggregate amount of investment income generated as a result of a prepayment penalty and/or acceleration fee.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): Not Applicable.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None


Staff Recommendation: NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to the disclosures in SSAP No. 26R—Bonds. The revisions expand the called bond disclosures to also include bonds in which are terminated early through a tender offer.

30. The financial statements shall include the following disclosures:

   i. For securities sold, redeemed or otherwise disposed as a result of a callable or tender offer feature (including make-whole call provisions), disclose the number of CUSIPs sold, disposed or otherwise redeemed and the aggregate amount of investment income generated as a result of a prepayment penalty and/or acceleration fee.
Staff Review Completed by: Jim Pinegar, NAIC Staff
September 2020

Status:
On November 12, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 26R—Bonds, as illustrated above, to expand the called bond disclosures to also include bonds terminated early through a tender offer.

On March 15, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to SSAP No. 26R—Bonds, as illustrated above, to expand the called bond disclosures to also include bonds terminated early through a tender offer.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: SSAP No. 32R – Publicly Traded Preferred Stock Warrants

Check (applicable entity):

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Description of Issue: NAIC staff received inquiries on which standard and reporting schedule would be most appropriate for publicly traded preferred stock warrants. A stock warrant represents the right to purchase a company's stock at a specific price and at a specific date and are typically issued directly by a company to an investor. When a stock warrant is exercised, the shares of the stock received are issued directly from the company itself, rather than another investor.

Stock warrants generally fall into scope of SSAP No. 86—Derivatives, although there is a special carveout for publicly traded common stock warrants (see existing authoritative literature section). However due to the fact that the only difference between publicly traded common and preferred stock warrants is the type of stock an entity would receive (i.e. common or preferred stock), NAIC staff believe that publicly traded preferred stock warrants should receive a similar carveout from SSAP No. 86 and similar accounting and reporting treatment.

This agenda item proposes 1) to expand the scope of SSAP No. 32R—Preferred Stock to include publicly traded preferred stock warrants and 2) require publicly traded preferred stock warrants to be reported at fair value.

Existing Authoritative Literature:

Warrants, both public and private are described in SSAP No. 86, however publicly traded (common) stock warrants are scoped into SSAP No. 30—Unaffiliated Common Stock as highlighted below. (Note: only relevant excerpts have been included below.)

SSAP No. 86:

5. Derivative instruments include, but are not limited to; options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, futures, structured notes with risk of principal/original investment loss based on the terms of the agreement (in addition to default risk), and any other agreements or instruments substantially similar thereto or any series or combination thereof.

j. “Warrants” are instruments that give the holder the right to purchase an underlying financial instrument at a given price and time or at a series of prices and times outlined in the warrant agreement. Warrants may be issued alone or in connection with the sale of other securities, for example, as part of a merger or recapitalization agreement, or to facilitate divestiture of the securities of another business entity. Publicly traded stock warrants are captured in scope of SSAP No. 30R—Unaffiliated Common Stock. All other warrants, including non-publicly traded stock warrants, shall be captured in scope of SSAP No. 86.
Accordingly, as referenced in SSAP No. 86, publicly traded common stock warrants are captured within the scope of SSAP No. 30R, as highlighted below.

SSAP No. 30R:

4. In addition, the following equity investments are captured within scope of this statement:

   a. Master limited partnerships trading as common stock and American deposit receipts only if the security is traded on the New York or NASDAQ exchange;

   b. Publicly traded common stock warrants;

   c. Shares of SEC registered Investment Companies captured under the Investment Company Act of 1940 (open-end investment companies (mutual funds), closed-end funds and unit investment trusts), regardless of the types or mix of securities owned by the fund (e.g., bonds or stocks);

   d. Exchange Traded Funds, except for those identified for bond or preferred stock treatment, as identified in Part Three of the Purposes and Procedures Manual of the NAIC Investment Analysis Office and published on the SVO’s web page of www.NAIC.org;

   e. Foreign open-end investment funds governed and authorized in accordance with regulations established by the applicable foreign jurisdiction. Other foreign funds are excluded from the scope of this statement; and

   f. Equity interests in certified capital companies in accordance with INT 06-02: Accounting and Reporting for Investments in a Certified Capital Company (CAPCO).

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:

NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 32R—Preferred Stock and SSAP No. 86—Derivatives, which would scope publicly traded preferred stock warrants into SSAP No. 32R. This would result in publicly traded preferred stock warrants receiving similar treatment as publicly traded common stock warrants. Additionally, the publicly traded preferred stock warrants would be accounted for as perpetual preferred stock, thus requiring to be accounted for at fair value.

Proposed edits to SSAP No. 86—Derivatives:

5. Derivative instruments include, but are not limited to; options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, futures, structured notes with risk of principal/original investment loss based on the terms of the agreement (in addition to default risk), and any other agreements or instruments substantially similar thereto or any series or combination thereof.
j. “Warrants” are instruments that give the holder the right to purchase an underlying financial instrument at a given price and time or at a series of prices and times outlined in the warrant agreement. Warrants may be issued alone or in connection with the sale of other securities, for example, as part of a merger or recapitalization agreement, or to facilitate divestiture of the securities of another business entity. Publicly traded stock warrants are captured in scope of SSAP No. 30R—Unaffiliated Common Stock or SSAP No. 32R—Preferred Stock. All other warrants, including non-publicly traded stock warrants, shall be captured in scope of SSAP No. 86.

Proposed edits to SSAP No. 32R—Preferred Stock:

SUMMARY CONCLUSION

3. Preferred stock which may or may not be publicly traded is a security that represents ownership of a corporation and gives the holder a claim prior to the claim of common stockholders on earnings and also generally on assets in the event of liquidation. Most preferred stock pays a fixed dividend that is paid prior to the common stock dividend, stated in a dollar amount or as a percentage of par value. Preferred stock does not usually carry voting rights. Preferred stock has characteristics of both common stock and debt. Preferred stock shall include:

a. Redeemable preferred stock, which is preferred stock subject to mandatory redemption requirements or whose redemption is at the option of the holders. Redeemable preferred stock is any stock which 1) the issuer undertakes to redeem at a fixed or determinable price on the fixed or determinable date or dates, whether by operation of a sinking fund or otherwise; or 2) is redeemable at the option of the holders. Preferred stock which meet one or more of these criteria would be classified as redeemable preferred stock, regardless of other attributes such as voting rights or dividend rights.

b. Perpetual preferred stock, which is preferred stocks which are not redeemable or for which redemption is not at the option of the holder (non-redeemable preferred stock). Perpetual preferred stock is any preferred stock which does not meet the criteria to be classified as redeemable preferred stock pursuant to paragraph 3.a.

c. Publicly traded preferred stock warrants.

Balance Sheet Amount

11. Preferred stock shall be valued based on (a) the underlying characteristics (redeemable, perpetual or mandatory convertible), (b) the quality rating expressed as an NAIC designation, and (c) whether an asset valuation reserve (AVR) is maintained by the reporting entity:

a. For reporting entities that do not maintain an AVR:

i. Highest-quality or high-quality redeemable preferred stocks (NAIC designations 1 and 2), which have characteristics of debt securities, shall be valued at cost or amortized cost. All other redeemable preferred stocks (NAIC designations 3 to 6) shall be reported at the lower of cost, amortized cost, or fair value.

ii. Perpetual preferred stock and publicly traded preferred stock warrants shall be reported at fair value, not to exceed any currently effective call price.

iii. Mandatory convertible preferred stocks (regardless if the preferred stock is redeemable or perpetual) shall be reported at fair value, not to exceed any currently effective call price, in the periods prior to conversion. Upon conversion to common stock, these securities shall be in scope of SSAP No. 30R.
iv. For preferred stocks reported at fair value, unrealized gains and losses shall be recorded as a direct credit or charge to unassigned funds (surplus)

b. For reporting entities that maintain an AVR:

i. Highest-quality, high-quality or medium quality redeemable preferred stocks (NAIC designations 1 to 3) shall be valued at amortized cost. All other redeemable preferred stocks (NAIC designations 4 to 6) shall be reported at the lower of amortized cost or fair value.

ii. Perpetual preferred stocks and publicly preferred stock warrants shall be valued at fair value, not to exceed any currently effective call price.

iii. Mandatory convertible preferred stocks (regardless if the preferred stock is redeemable or perpetual) shall be reported at fair value, not to exceed any currently effective call price, in the periods prior to conversion. Upon conversion to common stock, these securities shall be in scope of SSAP No. 30R.

iv. For preferred stocks reported at fair value, the accounting for unrealized gains and losses shall be in accordance with SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve.

Impairment of Perpetual Preferred Stock

14. For any decline in the fair value of perpetual preferred stock or publicly traded preferred stock warrants, which is determined to be other-than-temporary (INT 06-07), the perpetual preferred stock or warrant shall be written down to fair value as the new cost basis and the amount of the write down shall be accounted for as a realized loss. For reporting entities required to maintain an AVR, realized losses shall be accounted for in accordance with SSAP No. 7. Subsequent fluctuations in fair value shall be recorded as unrealized gains or losses. Future declines, which are determined to be other-than-temporary, shall be recognized as realized losses. A decline in fair value which is other-than-temporary includes situations where the reporting entity has made a decision to sell a preferred stock at an amount below its carrying value.

Staff Review Completed by: Jim Pinegar, NAIC Staff – September 2020

Status:
On November 12, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 32R—Preferred Stock and SSAP No. 86—Derivatives, as illustrated above, to scope publicly traded preferred stock warrants into SSAP No. 32R with accounting at fair value.

On March 15, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to SSAP No. 32R—Preferred Stock and SSAP No. 86—Derivatives, as shown above. These revisions scope publicly traded preferred stock warrants into SSAP No. 32R with accounting at fair value.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: SSAP No. 43R – Government-Sponsored Enterprises – Credit Risk Transfer Transactions

Check (applicable entity):

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Description of Issue:

During the 2019 Spring National Meeting, the Working Group adopted agenda item 2018-18: Structured Notes, which expanded the scope of SSAP No. 43R—Loan-Backed and Structures Securities to include certain Government-Sponsored Enterprises (GSE) – Credit Risk Transfer (CRT) Transactions.

Credit risk transfer securities are mortgage-referenced securities issued by government sponsored entities that are tied to a referenced pool of mortgages. These are instruments in which the payments received are linked to the interest and principal repayment of underlying mortgage loans from those identified in a particular pool of mortgages. For these instruments, investors may not receive a full return of principal as principal repayment is contingent on the ultimate repayment by the mortgage loan borrowers (as credit risk has been transferred to the investor). The program naming convention for CRT’s was identified as Structured Agency Credit Risk (STACR) for Freddie Mac and Connecticut Avenue Securities (CAS) for Fannie Mae.

This agenda item has been drafted to reflect recent changes to the Freddie Mac STACR and Fannie Mae CAS programs. It is anticipated that future Freddie Mac STACR and Fannie Mae CAS issuances will be solely conducted through a Real Estate Mortgage Investment Conduit (REMIC) trust. The REMIC is functionally equivalent to the original Freddie Mac STACR and Fannie Mae CAS programs, in that the trusts will pay interest and principal to investors on a monthly basis. All other material characteristics also remain unaffected as the investment represents a large, diversified reference pool, multiple tranches are available to accommodate various risk appetites, and the notes are highly liquid with an estimated $2 billion in buy/sale trades occurring each month. Also unchanged is that the STACR notes are not guaranteed by Freddie Mac (i.e., credit risk has been transferred) and CAS notes are not guaranteed by Freddie Mac, and both entities maintain the senior risk tranche, which is unfunded and not issued for public investors.

The primary difference in the use of a REMIC trust is that counterparty risk exposure to Freddie Mac and Fannie Mae is reduced as the trust is designed to stand on its own. The trust’s assets are intended to fund interest and principal payments on the notes, thus insulating investors from a possible Freddie Mac or Fannie Mae insolvency. While several other benefits are touted, the use of a REMIC will also not subject international investors to U.S. withholding tax requirements, likely resulting in higher international investor participation.

In collaboration with NAIC Securities Valuation Office (SVO) staff, SAPWG support staff has confirmed that the anticipated use of a REMIC trust remains functionally equivalent and retains the same material risk structure as the original STACR and CAS programs. Additionally, investment in securities issued by a GSE REMIC trust remains within the review scope of the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual). Per part 4 of the P&P Manual, Mortgage Referenced Securities are not eligible for filing exemption and are subject to assessment by the Structures Securities Group.
This agenda item proposes to 1) include STACR and CAS REMIC’s into the scope of SSAP No. 43R and, 2) align SSAP No. 43R guidance regarding the financial modeling of mortgage referenced securities to the requirements as directed in the P&P Manual.

Existing Authoritative Literature:

**SSAP No. 43R—Loan-Backed and Structured Securities**

The inclusion GSE CRT securities into the scope of SSAP No. 43R is referenced in paragraph 5:

5. Mortgage-referenced securities do not meet the definition of a loan-backed or structured security but are explicitly captured in scope of this statement. In order to qualify as a mortgage-referenced security, the security must be issued by a government sponsored enterprise in the form of a “credit risk transfer” in which the issued security is tied to a referenced pool of mortgages. These securities do not qualify as “loan-backed securities” as the pool of mortgages are not held in trust and the amounts due under the investment are not backed or secured by the mortgage loans. Rather, these items reflect instruments in which the payments received are linked to the credit and principal payment risk of the underlying mortgage loan borrowers captured in the referenced pool of mortgages. For these instruments, reporting entity holders may not receive a return of their full principal as principal repayment is contingent on repayment by the mortgage loan borrowers in the referenced pool of mortgages. Unless specifically noted, the provisions for loan-backed securities within this standard apply to mortgage-referenced securities.

Financial modeling of CRT Securities is referenced in paragraph 27:

Designation Guidance

27. For RMBS/CMBS securities within the scope of this statement, the initial NAIC designation used to determine the carrying value method and the final NAIC designation for reporting purposes is determined using a multi-step process. The Purposes and Procedures Manual of the NAIC Investment Analysis Office provides detailed guidance. A general description of the processes is as follows:

a. Financial Modeling: The NAIC identifies securities where financial modeling must be used to determine the NAIC designation. NAIC designation based on financial modeling incorporates the insurers’ carrying value for the security. For those securities that are financially modeled, the insurer must use NAIC CUSIP specific modeled breakpoints provided by the modelers in determining initial and final designation for these identified securities. Securities where modeling results in zero expected loss in all scenarios are automatically considered to have a final NAIC designation of NAIC 1, regardless of the carrying value. The three-step process for modeled securities is as follows:

i. Step 1: Determine Initial Designation – The current amortized cost (divided by remaining par amount) of a loan-backed or structured security is compared to the modeled breakpoint values assigned to the six (6) NAIC designations for each CUSIP to establish the initial NAIC designation.

ii. Step 2: Determine Carrying Value Method – The carrying value method, either the amortized cost method or the lower of amortized cost or fair value method, is then

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1 Currently, only Fannie Mae and Freddie Mac are the government sponsored entities that issue qualifying mortgage-referenced securities. However, this guidance would apply to mortgage-referenced securities issued by any other government sponsored entity that subsequently engages in the transfer of residential mortgage credit risk.
determined as described in paragraph 26 based upon the initial NAIC designation from Step 1.

iii. Step 3: Determine Final Designation – The final NAIC designation that shall be used for investment schedule reporting is determined by comparing the carrying value (divided by remaining par amount) of a security (based on paragraph 27.a.ii.) to the NAIC CUSIP specific modeled break point values assigned to the six (6) NAIC designations for each CUSIP. This final NAIC designation shall be applicable for statutory accounting and reporting purposes (including establishing the AVR charges). The final designation is not used for establishing the appropriate carrying value method in Step 2 (paragraph 27.a.ii.).

b. All Other Loan-Backed and Structured Securities: For loan-backed and structured securities not subject to paragraphs 27.a. (financial modeling) follow the established designation procedures according to the appropriate section of the Purposes and Procedures Manual of the NAIC Investment Analysis Office. The NAIC designation shall be applicable for statutory accounting and reporting purposes (including determining the carrying value method and establishing the AVR charges). The carrying value method is established as described in paragraph 26. Examples of these securities include, but are not limited to, mortgage-referenced securities, equipment trust certificates, credit tenant loans (CTL), 5*/6* securities, interest only (IO) securities, securities with CRP ratings (excluding RMBS/CMBS), and loan-backed and structured securities with SVO assigned NAIC designations.

Specific Interim Reporting Guidance for RMBS/CMBS Securities

28. The guidance in this paragraph shall be applied in determining the reporting method for residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS) acquired in the current year for quarterly financial statements. Securities reported as of the prior-year end shall continue to be reported under the prior-year end methodology for the current-year quarterly financial statements. For year-end reporting, securities shall be reported in accordance with paragraph 27, regardless of the quarterly methodology used.

a. Reporting entities that acquired the entire financial modeling database for the prior-year end are required to follow the financial modeling methodology (paragraph 27.a.) for all securities acquired in the subsequent year that were included in the financial modeling data acquired for the prior year-end.

b. Reporting entities that acquired identical securities (identical CUSIP) to those held and financially modeled for the prior year-end are required to follow the prior year-end financial modeling methodology (paragraph 27.a.) for these securities acquired subsequent to year-end.

c. Reporting entities that do not acquire the prior-year financial modeling information for current-year acquired individual CUSIPS, and are not captured within paragraphs 28.a. or 28.b., are required to follow the analytical procedures for non-financially modeled securities (paragraph 27.b. as appropriate). Reporting entities that do acquire the individual CUSIP information from the prior-year financial modeling database shall use that information for interim reporting.

d. Reporting entities that acquire securities not previously modeled at the prior year-end are required to follow the analytical procedures for non-financially modeled securities (paragraph 27.b. as appropriate).
Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual); Part 4 – Mortgage Reference Securities:

Definition

29. A Mortgage Referenced Security has the following characteristics: A Mortgage Referenced Security’s coupon and/or principal payments are linked, in whole or in part, to prices of, or payment streams from, real estate, index or indices related to real estate, or assets deriving their value from instruments related to real estate, including, but not limited to, mortgage loans.

Not Filing Exempt

30. A Mortgage Referenced Security is not eligible for filing exemption but is subject to the filing requirement.

NAIC Risk Assessment

31. In determining the NAIC Designation of a Mortgage Referenced Security, the SSG may use the financial modeling methodology discussed in this Part, adjusted (if and as necessary) to the specific reporting and accounting requirements applicable to Mortgage Referenced Securities.

Quarterly Reporting for Mortgage Reference Securities

32. To determine the NAIC Designation to be used for quarterly financial statement reporting for a Mortgage Reference Security purchased subsequent to the annual surveillance described in this Part, the insurer uses the prior year-end modeling data for that CUSIP (which can be obtained from the NAIC) until the annual surveillance data is published for the current year. For a Mortgage Reference Security that is not in the prior year-end modeling data for that CUSIP, the insurer may follow the instructions in Part Two of this manual for the assignment of the SVO Administrative Symbol “Z” provided the insurer owned security meets the criteria for a security that is in transition in reporting or filing.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group:
Relevant background from agenda item 2018-18 was included in the ‘Description of Issue’ section.

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 43R—Loan-Backed and Structures Securities, incorporating minor scope modifications to reflect recent changes to the STACR and CAS programs. The proposed edits would allow credit risk transfer securities from Freddie Mac and Fannie Mae to remain in scope when a REMIC structure is used in the STACR program or CAS program.
5. Mortgage-referenced securities do not meet the definition of a loan-backed or structured security but are explicitly captured in scope of this statement. In order to qualify as a mortgage-referenced security, the security must be issued by a government sponsored enterprise\(^2\) or by a special purpose trust in a transaction sponsored by a government sponsored enterprise in the form of a “credit risk transfer” in which the issued security is tied to a referenced pool of mortgages and. These securities do not qualify as “loan-backed securities” as the pool of mortgages are not held in trust and the amounts due under the investment are not backed or secured by the mortgage loans. Rather, these items reflect instruments in which the payments received are linked to the credit and principal payment risk of the underlying mortgage loan borrowers captured in the referenced pool of mortgages. For these instruments, reporting entity holders may not receive a return of their full principal as principal repayment is contingent on repayment by the mortgage loan borrowers in the referenced pool of mortgages. Unless specifically noted, the provisions for loan-backed securities within this standard apply to mortgage-referenced securities.

27. For RMBS/CMBS securities within the scope of this statement, the initial NAIC designation used to determine the carrying value method and the final NAIC designation for reporting purposes is determined using a multi-step process. The *Purposes and Procedures Manual of the NAIC Investment Analysis Office* provides detailed guidance. A general description of the processes is as follows:

a. Financial Modeling: Pursuant to the P&P manual, the NAIC identifies select securities where financial modeling must be used to determine the NAIC designation. NAIC designation based on financial modeling incorporates the insurers’ carrying value for the security. For those securities that are financially modeled, the insurer must use NAIC CUSIP specific modeled breakpoints provided by the modelers in determining initial and final designation for these identified securities. Securities where modeling results in zero expected loss in all scenarios are automatically considered to have a final NAIC designation of NAIC 1, regardless of the carrying value. The three-step process for modeled securities is as follows:

   i. **Step 1:** Determine Initial Designation – The current amortized cost (divided by remaining par amount) of a loan-backed or structured security is compared to the modeled breakpoint values assigned to the six (6) NAIC designations for each CUSIP to establish the initial NAIC designation.

   ii. **Step 2:** Determine Carrying Value Method – The carrying value method, either the amortized cost method or the lower of amortized cost or fair value method, is then determined as described in paragraph 26 based upon the initial NAIC designation from Step 1.

   iii. **Step 3:** Determine Final Designation – The final NAIC designation that shall be used for investment schedule reporting is determined by comparing the carrying value (divided by remaining par amount) of a security (based on paragraph 27.a.ii.) to the NAIC CUSIP specific modeled breakpoint values assigned to the six (6) NAIC designations for each CUSIP. This final NAIC designation shall be applicable for statutory accounting and reporting purposes (including establishing the AVR charges). The final designation is not used for establishing the appropriate carrying value method in Step 2 (paragraph 27.a.ii.).

b. All Other Loan-Backed and Structured Securities: For securities loan-backed and structured securities—not subject to paragraphs 27.a. (financial modeling) follow the

\(^2\) Currently, only Fannie Mae and Freddie Mac are the government sponsored entities that either directly issue qualifying mortgage-referenced securities or sponsor transactions in which special purpose trust issues qualifying mortgage-reference securities. However, this guidance would apply to mortgage-referenced securities issued by any other government sponsored entity that subsequently engages in the transfer of residential-mortgage credit risk.
established designation procedures according to the appropriate section of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*. The NAIC designation shall be applicable for statutory accounting and reporting purposes (including determining the carrying value method and establishing the AVR charges). The carrying value method is established as described in paragraph 26. Examples of these securities include, but are not limited to, mortgage-referenced securities, equipment trust certificates, credit tenant loans (CTL), 5*/6* securities, interest only (IO) securities, securities with CRP ratings (excluding RMBS/CMBS), and loan-backed and structured securities and mortgage-referenced securities with SVO assigned NAIC designations.

**Specific Interim Reporting Guidance Financially Modeled for RMBS/CMBS Securities**

28. **For securities that will be financially modeled under paragraph 27.** The guidance in this paragraph shall be applied in determining the reporting method for such securities (residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS) acquired in the current year for quarterly financial statements. Securities reported as of the prior-year end shall continue to be reported under the prior-year end methodology for the current-year quarterly financial statements. For year-end reporting, securities shall be reported in accordance with paragraph 27, regardless of the quarterly methodology used.

   a. Reporting entities that acquired the entire financial modeling database for the prior-year end are required to follow the financial modeling methodology (paragraph 27.a.) for all securities acquired in the subsequent year that were included in the financial modeling data acquired for the prior year-end.

   b. Reporting entities that acquired identical securities (identical CUSIP) to those held and financially modeled for the prior year-end are required to follow the prior year-end financial modeling methodology (paragraph 27.a.) for these securities acquired subsequent to year-end.

   c. Reporting entities that do not acquire the prior-year financial modeling information for current-year acquired individual CUSIPS, and are not captured within paragraphs 28.a. or 28.b., are required to follow the analytical procedures for non-financially modeled securities (paragraph 27.b. as appropriate). Reporting entities that do acquire the individual CUSIP information from the prior-year financial modeling database shall use that information for interim reporting.

   d. Reporting entities that acquire securities not previously modeled at the prior year-end are required to follow the analytical procedures for non-financially modeled securities (paragraph 27.b. as appropriate).

**Staff Review Completed by:**
Jim Pinegar – August 2020
NAIC Staff

**Status:**
On November 12, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to *SSAP No. 43R—Loan-Backed and Structures Securities,* as illustrated above, to incorporate minor scope modifications to reflect recent changes to the STACR and CAS programs. The proposed edits would allow credit risk transfer securities from Freddie Mac and Fannie Mae to remain in scope of SSAP No. 43R when a REMIC structure is used in the STACR program or CAS program.
On March 15, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to *SSAP No. 43R—Loan-Backed and Structures Securities*, as illustrated above, to incorporate minor scope modifications to reflect recent changes to the Freddie Mac Structured Agency Credit Risk (STACR) and Fannie Mae Connecticut Avenue Securities (CAS) programs. The edits allow credit risk transfer securities from Freddie Mac and Fannie Mae to remain in scope of SSAP No. 43R when a REMIC structure is used in the STACR program or CAS program.
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Issue: SSAP No. 97 – Audit Opinions

Check (applicable entity):

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Description of Issue: SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities provides guidance for the various audit opinions that can be issued when an entity records certain investments utilizing the U.S. GAAP equity method of accounting.

The complete guidance for the various audit opinions is included in the ‘Existing Authoritative Literature,’” however the relevant guidance is summarized as:

- Disclaimers of opinion shall be nonadmitted.
- Qualified opinions due to a scope limitation can only be admitted if the limitation is quantified, then the quantified limitation is nonadmitted.
- Qualified opinions due to a GAAP departure can only be admitted if the departure is quantified (then the departure is nonadmitted), OR if the departure is as the result of utilizing a statutory accounting principle in lieu of following GAAP (in such cases, a quantification of the departure is not required).
- Adverse opinions due to a GAAP departure can only be admitted if the departure is quantified (then the quantified departure is nonadmitted), OR if the departure is as the result of utilizing a statutory accounting principle in lieu of following GAAP (in such cases, a quantification of the departure is not required).

The allowance of qualified or adverse audit opinions for admission of SCA investments without quantification are only permitted for U.S. insurance entities (commonly referred to as an 8.b.i entity). This agenda item proposes to expand the quantification exception guidance to 8.b.iii entities (referred to as U.S. GAAP SCA entities) in limited situations. Particularly, the proposed exception would allow U.S. GAAP SCA entities that depart from a U.S. GAAP provision that has been rejected for statutory accounting to be admitted SCAs without quantification if the departure from U.S. GAAP results in a more conservative position (i.e. fewer assets or greater liabilities), as a result of the departure.

Although specific quantification is not needed, this would require auditor certification that the departure from U.S. GAAP results in a more conservative position. From a situation shared in which an 8.b.iii SCA (U.S. GAAP entity) was following provisions similar to the insurer with regards to revenue recognition, the auditor noted that the U.S. GAAP revenue recognition provisions (which requires consideration of future, expected activity) warranted a qualified opinion. Under the existing guidance, this qualified opinion results in nonadmittance of the SCA because it could not be quantified, which was material to the reporting entity. This nonadmittance treatment was noted to be punitive as the SCA was following processes that were consistent with SAP accounting that resulted in a more conservative financial statement representation of the SCA.

Existing Authoritative Literature: The entity types (8.b.i, 8.b.ii, etc.) referenced in the ‘Description of Issue,’ the audit opinion requirements and the permitted exceptions to the unqualified opinion requirements within SSAP No. 97 are below. Relevant guidance has been bolded for emphasis.
SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities

Applying the Market Valuation, Audited Statutory Equity and Audited GAAP Equity Methods

8. The admitted investments in SCA entities shall be valued using either the market valuation approach (as described in paragraph 8.a.), or one of the equity methods (as described in paragraph 8.b.) adjusted as appropriate in accordance with the guidance in SSAP No. 25—Affiliates and Other Related Parties, paragraph 17.d.

a. In order to use the market valuation approach for SCA entities, the following requirements apply:

i. The subsidiary must be traded on one of the following major exchanges: (1) the New York Stock Exchange, (2) the NASDAQ, or (3) the Japan Exchange Group;

ii. The reporting entity must submit subsidiary information to the NAIC SCA analysts for calculation of the subsidiary’s market value. Such calculation could result in further discounts in market value above the established base discounts based on ownership percentages detailed below;

iii. Ownership percentages for determining the discount rate shall be measured at the holding company level;

iv. If an investment in a SCA results in an ownership percentage between 10% and 50%, a base discount percentage between 0% and 20% on a sliding scale basis is required;

v. If an investment in a SCA results in an ownership percentage greater than 50% up to and including 80%, a base discount percentage between 20% and 30% on a sliding scale basis is required;

vi. If an investment in a SCA results in an ownership percentage greater than 80% up to and including 85%, a minimum base discount percentage of 30% is required;

vii. Further, the SCA must have at least two million shares outstanding, with a total market value of at least $50 million in the public’s control; and

viii. Any ownership percentages exceeding 85% will result in the SCA being recorded on an equity method.

b. If a SCA investment does not meet the requirements for the market valuation approach in paragraph 8.a. or, if the requirements are met, but a reporting entity elects not to use that approach, the reporting entity’s proportionate share of its investments in SCAs shall be recorded as follows:

i. **Investments in U.S. insurance SCA entities shall be recorded based on either**
   1) the underlying audited statutory equity of the respective entity’s financial statements, adjusted for any unamortized goodwill as provided for in SSAP No. 68—Business Combinations and Goodwill or 2) the underlying audited statutory equity of the respective entity’s financial statements, adjusted for any unamortized goodwill, modified to remove the impact of any permitted or prescribed accounting practices that depart from the NAIC Accounting Practices and Procedures Manual. Reporting entities shall record investments in U.S.
insurance SCA entities on at least a quarterly basis, and shall base the investment value on the most recent quarterly information available from the SCA. Entities may recognize their investment in U.S. insurance SCA entities based on the unaudited statutory equity in the SCAs year-end annual statement if the annual SCA audited financial statements are not complete as of the filing deadline. The recorded statutory equity shall be adjusted for audit adjustments, if any, as soon as the annual audited financial statements have been completed. Annual consolidated or combined audits are allowed if completed in accordance with the Model Regulation Requiring Annual Audited Financial Reports as adopted by the SCA’s domiciliary state;

iii. Investments in both U.S. and foreign noninsurance SCA entities that do not qualify under paragraph 8.b.ii., shall be recorded based on the audited U.S. GAAP equity of the investee. Foreign SCA entities are defined as those entities incorporated or otherwise legally formed under the laws of a foreign country. Additional guidance on investments in downstream holding companies is included in paragraphs 22-27. Additional guidance on the use of audited foreign GAAP basis financial statements for the U.S. GAAP equity valuation amount is included in paragraph 23.b.

Qualified Versus Unqualified Opinions

21. Various opinions can be issued in which an entity can record certain investments under the GAAP Equity method of accounting. The reporting entity shall record investments that require audited GAAP equity in the manner described below when the audit opinion on the GAAP financial statements contains the following language:

   a. The investment shall be nonadmitted if the audit opinion contains a disclaimer of opinion for the most recent statement of financial position presented in the financial statements.

   b. The investment shall be nonadmitted if the audit opinion contains a qualified opinion due to a scope limitation that impacts the most recent statement of financial position presented in the financial statements and the impact of the scope limitation cannot be quantified. However, if the impact of the scope limitation is quantified in the audited financial statements or the audit opinion, the investment shall be admitted and the reporting entity’s valuation of the investment shall be determined based on the GAAP equity of the investee, adjusted to exclude the impact of the quantified scope limitation.

   c. The investment shall be nonadmitted if the audit opinion contains a qualified opinion due to a departure from GAAP that impacts the most recent statement of financial position presented in the financial statements and the impact of such departure is not quantified in either the auditor’s report or the footnotes to the financial statements (see quantification exception related to the valuation of a U.S. insurance entity on the basis of U.S. statutory accounting principles discussed below). However, if the impact of the departure from GAAP is quantified in the audited financial statements or the audit opinion, the investment shall be admitted and the reporting entity’s valuation of the investment shall be determined based on the GAAP equity of the investee, adjusted to exclude the impact of the quantified departure from GAAP. EXCEPTION: There is no need to quantify the impact of a departure from GAAP in either the auditor’s report or the footnotes to the financial statements if a qualified audit opinion is issued due to a departure from GAAP and the departure is related to the valuation of an U.S. insurance entity on the basis of U.S. statutory accounting principles. In such cases, the investment shall be admitted without quantifying the departure.
The investment shall be nonadmitted if the audit opinion contains an adverse opinion due to a departure from GAAP that impacts the most recent statement of financial position presented in the financial statements and the impact of such departure is not quantified in either the auditor’s report or the footnotes to the financial statements (see quantification exception related to the valuation of a U.S. insurance entity on the basis of U.S. statutory accounting principles discussed below). However, if the impact of the departure from GAAP is quantified in the audited financial statements or the audit opinion, the investment shall be admitted and the reporting entity’s valuation of the investment shall be determined based on the GAAP equity of the investee, adjusted to exclude the impact of the quantified departure from GAAP. EXCEPTION: There is no need to quantify the impact of a departure from GAAP in either the auditor’s report or the footnotes to the financial statements if an adverse audit opinion is issued due to a departure from GAAP and the departure is related to the valuation of an U.S. insurance entity on the basis of U.S. statutory accounting principles. In such cases, the investment shall be admitted without quantifying the departure.

The investment shall be nonadmitted if the audit report or accompanying financial statements/notes contains explanatory language indicating there is an unalleviated substantial doubt about the investee’s ability to continue as a going concern.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None


Staff Recommendation: NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and request comments on the extent to which situations exist that hinder admittance of 8.b.iii entities due to the departure of U.S. GAAP as a result of the inability to quantify the departure.

Staff Review Completed by: Jim Pinegar - NAIC Staff – September 2020

Status:
On November 12, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed this agenda item with a request for comments on the extent in which situations exist that hinder admittance of 8.b.iii entities due to the departure of U.S. GAAP.

On March 15, 2021, the Statutory Accounting Principles (E) Working Group disposed of this agenda item, without statutory revisions, as the issue of nonadmittance due to the inability to quantify a departure from U.S. GAAP is not prevalent.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: ASU 2020-06 - Convertible Instruments

Check (applicable entity):

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Description of Issue: ASU 2020-06, Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40), Accounting for Convertible Instruments and Contracts in an Entity’s Own Equity intends to address issues identified as a result of the complexity associated with applying U.S. generally accepted accounting principles (U.S. GAAP) for certain financial instruments with characteristics of liabilities and equity. Complexity associated with the accounting is a significant contributing factor to numerous U.S. GAAP financial statement restatements and has resulted in complexity for users attempting to understand the results of applying the current guidance.

Under current U.S. GAAP, there are five accounting models for convertible debt instruments. Except for the traditional convertible debt model that recognizes a convertible debt instrument as a single debt instrument, the other four models, with their different measurement guidance, require that a convertible debt instrument be separated (using different separation approaches) into a debt component and an equity or a derivative component. Convertible preferred stock also is required to be assessed under similar models. The amendments in ASU 2020-06 provide financial statement users with a simpler and more consistent starting point to perform analyses across entities. The amendments also improve the operability of the guidance and reduce, to a large extent, the complexities in the accounting for convertible instruments and the difficulties with the interpretation and application of the relevant guidance.

The amendments to the derivatives scope exception for contracts in an entity’s own equity change the population of contracts that are recognized as assets or liabilities. For a freestanding instrument, if the instrument qualifies for the derivatives scope exception under the amendment, an entity should record the instrument as equity. For an embedded feature, if the feature qualifies for the derivatives scope exception under the amendment, an entity should no longer bifurcate the feature and account for it separately.

ASU 2020-06 also provides updated guidance on earnings per share calculations.

Existing Authoritative Literature:

1. Earnings per share – Rejected as Not Applicable for Statutory Accounting:

The concept of earnings per share (Topic 260) has previously been reviewed with the following U.S. GAAP standards rejected as not applicable in Appendix D—Nonapplicable GAAP Pronouncements:

- FASB Statement No. 128, Earnings per Share (FAS 128)
- EITF 07-04, Application of the Two-Class Method under FASB Statement No. 128 to Master Limited Partnerships

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2. Distinguishing Liabilities from Equity / Derivatives and Hedging:

SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets defines a liability with excerpts below:

Financial Instruments with Characteristics of both Liabilities and Equity

27. Issued, free-standing financial instruments with characteristics of both liability and equity shall be reported as a liability to the extent the instruments embodies an unconditional obligation of the issuer. (Pursuant to SSAP No. 86, embedded features in derivative contracts shall not be separated from the host contract for separate recognition.) Free-standing financial instruments that meet any of the criteria below meet the definition of a liability:

   a. A mandatorily redeemable financial instrument shall be classified as a liability unless the redemption is required to occur only upon the liquidation or termination of the issuing reporting entity.

   b. A financial instrument, other than an outstanding share, that at inception both 1) embodies an obligation to repurchase the issuer’s equity shares or is indexed to such an obligation and 2) requires or may require the issuer to settle the obligation by transferring assets.

   c. Obligations that permit the holder to require the issuer to transfer assets.

   d. A financial instrument is a liability if the issuer must settle the obligation by issuing a variable number of its equity shares and the obligation’s monetary value is based solely or predominantly on: 1) a fixed monetary amount, 2) variation in something other than the fair value of the issuer’s equity shares, or 3) variations inversely related to changes in the fair value of the issuer’s equity shares.

   e. Instruments in which the counterparty (holder) is not exposed to the risks and benefits that are similar to those of a holder of an outstanding share of the entity’s equity shall be classified as a liability.

28. If a free-standing financial instrument will be redeemed only upon the occurrence of a conditional event, redemption of that instrument is conditional and, therefore, the instrument does not meet the definition of mandatorily redeemable financial instrument. However, that financial instrument shall be assessed each reporting period to determine whether circumstances have changed such that the instrument meets the definition of a mandatorily redeemable instrument (that is, the event is no longer conditional). If the event has occurred, the condition is resolved, or the event has become certain to occur, the financial instrument shall be reclassified as a liability.

29. The classification of a free-standing financial instrument as a liability or equity shall only apply to the instrument issuer. Holders or purchasers of such instruments shall refer to the appropriate investment statement for valuation and reporting.

SSAP No. 72—Surplus and Quasi-Reorganizations

Capital Stock

3. The articles of incorporation set forth the number of authorized shares of capital stock and the par value of each share. The capital stock account represents the number of shares issued times the par value of each share. When no par value is set forth, the reporting entity shall declare a “stated value” and record such amount in the capital stock account. Changes in the par value of a reporting entity’s capital stock shall be reflected as a reclassification between the capital stock account and gross paid-in and contributed surplus. Issued, free-standing financial instruments with characteristics of both liability and equity shall be reported as a liability to the extent described in SSAP No. 5R.
SSAP No. 104R—Share-Based Payments, Exhibit A – Classification Criteria: Liability or Equity

Mandatorily Redeemable Financial Instruments

3. A mandatorily redeemable financial instrument shall be classified as a liability unless the redemption is required to occur only upon the liquidation or termination of the reporting entity.

4. A financial instrument that embodies a conditional obligation to redeem the instrument by transferring assets upon an event not certain to occur becomes mandatorily redeemable if that event occurs, the condition is resolved, or the event becomes certain to occur.

5. In determining if an instrument is mandatorily redeemable, all terms within a redeemable instrument shall be considered. The following items do not affect the classification of a mandatorily redeemable financial instrument as a liability:
   a. A term extension option
   b. A provision that defers redemption until a specified liquidity level is reached
   c. A similar provision that may delay or accelerate the timing of a mandatory redemption.

6. If a financial instrument will be redeemed only upon the occurrence of a conditional event, redemption of that instrument is conditional and, therefore, the instrument does not meet the definition of mandatorily redeemable financial instrument in this statement. However, that financial instrument would be assessed at each reporting period to determine whether circumstances have changed such that the instrument now meets the definition of a mandatorily redeemable instrument (that is, the event is no longer conditional). If the event has occurred, the condition is resolved, or the event has become certain to occur, the financial instrument is reclassified as a liability.

Obligations to Repurchase Issuer’s Equity Shares by Transferring Assets

7. An entity shall classify as a liability (or an asset in some circumstances) any financial instrument, other than an outstanding share, that, at inception, has both of the following characteristics:
   a. It embodies an obligation to repurchase the issuer’s equity shares, or is indexed to such an obligation, and
   b. It requires or may require the issuer to settle the obligation by transferring assets.

8. In this statement, “indexed to” is used interchangeably with “based on variations in the fair value of.” The phrase “requires or may require” encompasses instruments that either conditionally or unconditionally obligate the issuer to transfer assets. If the obligation is conditional, the number of conditions leading up to the transfer of assets is irrelevant.

9. Examples of financial instruments that meet the criteria in paragraph 7 of this Exhibit include forward purchase contracts or written put options on the issuer’s equity shares that are to be physically settled or net cash settled.

10. All obligations that permit the holder to require the issuer to transfer assets result in liabilities, regardless of whether the settlement alternatives have the potential to differ.
Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): The Working Group addressed similar issue in agenda item 2019-43, and adopted language that was included in the “Existing Authoritative Literature” section, primarily in SSAP No. 5R.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:
NAIC staff recommends the Working Group move this item to the active listing, categorized as nonsubstantive, and expose revisions to SSAP No. 5R, SSAP No. 72 and SSAP No. 86 to reject ASU 2020-06, Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40), Accounting for Convertible Instruments and Contracts in an Entity’s Own Equity for statutory accounting as this update primarily addresses various convertible debt valuation models (a concept not employed by statutory accounting) as well as require bifurcating embedded derivative components (a concept not permitted under statutory accounting).

Staff Review Completed by:
Jake Stultz, NAIC Staff – September 2020

Status:
On November 12, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets, SSAP No. 72—Surplus and Quasi-Reorganizations and SSAP No. 86—Derivatives, to reject ASU 2020-06, Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40), Accounting for Convertible Instruments and Contracts in an Entity’s Own Equity, ASU 2018-03, Recognition and Measurement of Financial Assets and Financial Liabilities, and ASU 2016-03, Intangibles—Goodwill and Other, Business Combinations, Consolidation, Derivatives and Hedging.

SSAP No. 5R

39. This statement rejects ASU 2020-06, Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40), Accounting for Convertible Instruments and Contracts in an Entity’s Own Equity.

SSAP No. 72

30. This statement rejects ASU 2020-06, Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40), Accounting for Convertible Instruments and Contracts in an Entity’s Own Equity.

SSAP No. 86

72. This statement rejects ASU 2020-06, Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40), Accounting for Convertible Instruments and Contracts in an Entity’s Own Equity, ASU 2018-03, Recognition and Measurement of Financial Assets and Financial Liabilities, and ASU 2016-03, Intangibles—Goodwill and Other, Business Combinations, Consolidation, Derivatives and Hedging.
On March 15, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions, as shown above to SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets, SSAP No. 72—Surplus and Quasi-Reorganizations and SSAP No. 86—Derivatives, to reject ASU 2020-06, Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40), Accounting for Convertible Instruments and Contracts in an Entity’s Own Equity for statutory accounting.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: ASU 2020-07 - Presentation and Disclosures by Not-for-Profit Entities

Check (applicable entity):
- Modification of Existing SSAP: P/C
- New Issue or SSAP: Life, Health
- Interpretation: 

Description of Issue: ASU 2020-07, Not-for-Profit Entities (Topic 958), Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets intends to improve U.S. generally accepted accounting principles (U.S. GAAP) by increasing the transparency of contributed nonfinancial assets for not-for-profit (NFP) entities through enhancements to financial statement presentation and disclosure. The amendments address stakeholder input concerning the lack of transparency about the measurement of contributed nonfinancial assets recognized by NFPs, as well as the amount of those contributions used in an NFP’s programs and other activities. These updates provide minor changes to U.S. GAAP disclosures for not-for-profit entities and require that contributed nonfinancial assets be reported on a separate line item in the statement of activities, apart from contributions of cash and other financial assets.

Existing Authoritative Literature: Disclosure requirements are included in most SSAPs, but none are specific to only not-for-profit entities.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): None

Staff Recommendation: NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2020-07, Not-for-Profit Entities (Topic 958), Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets as not applicable to statutory accounting.

This item is proposed to be rejected as not applicable as ASU 2020-07 is specific to not-for-profit entities, which for statutory accounting purposes are not subject to different disclosure treatment than other entity types.

Staff Review Completed by:
Jake Stultz, NAIC Staff – September 2020

Status:
On November 12, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2020-07, Not-for-Profit Entities (Topic 958), Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets as not applicable to statutory accounting.
On March 15, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, the proposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2020-07, Not-for-Profit Entities (Topic 958), Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets as not applicable to statutory accounting.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Accounting for Perpetual Bonds

Check (applicable entity):

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Description of Issue: Questions have arisen regarding accounting treatment for perpetual bonds held as investments within scope of SSAP No. 26R—Bonds. A perpetual bond is a fixed income security, representing a creditor relationship, with a fixed schedule of future payments, however it does not contain a maturity date - thus yielding the definitional term “perpetual.” These bonds are typically not redeemable at the option of the holder but likely possess call options for the benefit of the issuer.

Perpetual bonds possess characteristics very similar to that of perpetual preferred stock in that both offer a projected return for an indefinite of time. The similarities of these two securities extend beyond both having indefinite lives and receiving periodic, scheduled income cash flows (i.e. interest for perpetual bonds and dividends for perpetual preferred stock). Both investments 1) have a higher than average duration from their perpetual cashflows reflecting a greater market value sensitivity, up and down, to interest rate movements, 2) generally are subject to issuer call provisions, and 3) do not possess voting rights. The only primary cashflow difference between perpetual bonds and perpetual preferred stock is seniority in the event of a liquidation (bond typically place higher in the liquidation hierarchy) – which is why perpetual preferred stock may warrant a higher yield to compensate for seniority risk.

Existing Authoritative Literature:

SSAP No. 26R does not contain specific or differing valuation and reporting guidance for perpetual bonds. These investments would be captured in the existing valuation and reporting guidance for bonds that are not mandatory convertible, which anticipate a scheduled maturity date. Under this existing guidance, bonds are held at amortized cost or lower of amortized cost or fair value, depending on NAIC designation of the bond. Due to perpetual bonds lacking a maturity date (and possessing indefinite lives), they are unable to experience accretion or amortization to yield an amortized cost basis.

SSAP No. 26R—Bonds

11. Bonds, as defined in paragraph 3, shall be valued and reported in accordance with this statement, the Purposes and Procedures Manual of the NAIC Investment Analysis Office, and the designation assigned in the NAIC Valuations of Securities product prepared by the NAIC Securities Valuation Office (SVO).

   a. Bonds, except for mandatory convertible bonds: For reporting entities that maintain an asset valuation reserve (AVR), the bonds shall be reported at amortized cost, except for those with an NAIC designation of 6, which shall be reported at the lower of amortized cost or fair value. For reporting entities that do not maintain an AVR, bonds that are designated highest-quality and high-quality (NAIC designations 1 and 2, respectively) shall be reported at amortized cost; all other bonds (NAIC designations 3 to 6) shall be reported at the lower of amortized cost or fair value.
b. Mandatory convertible bonds: Mandatory convertible bonds are subject to special reporting instructions and are not assigned NAIC designations or unit prices by the SVO. The balance sheet amount for mandatory convertible bonds shall be reported at the lower of amortized cost or fair value during the period prior to conversion. This reporting method is not impacted by NAIC designation or information received from credit rating providers (CRPs). Upon conversion, these securities will be subject to the accounting guidance of the statement that reflects their revised characteristics. (For example, if converted to common stock, the security will be in scope of SSAP No. 30R—Unaffiliated Common Stock, if converted to preferred stock, the security will be in scope of SSAP No. 32—Preferred Stocks.)

Due to the numerous payment similarities between perpetual bonds and perpetual preferred stock, the accounting and reporting guidance for perpetual preferred stock is below. (Note: guidance below is from agenda item 2019-04: SSAP No. 32 – Investment Classification Project.) This agenda item substantially revises SSAP No. 32—Preferred Stock as a part of the Investment Classification Project. This guidance is anticipated for adoption during the Summer 2020 National Meeting.

SSAP No 32R—Preferred Stock

10. Preferred stock shall be valued based on (a) the underlying characteristics (redeemable, perpetual or mandatory convertible), (b) the quality rating expressed as an NAIC designation, and (c) whether an asset valuation reserve (AVR) is maintained by the reporting entity:

a. For reporting entities that do not maintain an AVR:

i. Highest-quality or high-quality redeemable preferred stocks (NAIC designations 1 and 2) shall be valued at amortized cost. All other redeemable preferred stocks (NAIC designations 3 to 6) shall be reported at the lower of amortized cost or fair value.

ii. Perpetual preferred stocks shall be reported at fair value, not to exceed any currently effective call price.

iii. Mandatory convertible preferred stocks (regardless if the preferred stock is redeemable or perpetual) shall be reported at fair value, not to exceed any currently effective call price, in the periods prior to conversion. Upon conversion to common stock, these securities shall be in scope of SSAP No. 30R.

iv. For preferred stocks reported at fair value, unrealized gains and losses shall be recorded as a direct credit or charge to unassigned funds (surplus).

b. For reporting entities that maintain an AVR:

i. Highest-quality, high-quality or medium quality redeemable preferred stocks (NAIC designations 1 to 3) shall be valued at amortized cost. All other redeemable preferred stocks (NAIC designations 4 to 6) shall be reported at the lower of amortized cost or fair value.

ii. Perpetual preferred stocks shall be valued at fair value, not to exceed any currently effective call price.

iii. Mandatory convertible preferred stocks (regardless if the preferred stock is redeemable or perpetual) shall be reported at fair value, not to exceed any currently effective call price, in the periods prior to conversion. Upon conversion to common stock, these securities shall be in scope of SSAP No. 30R.
iv. For preferred stocks reported at fair value, the accounting for unrealized gains and losses shall be in accordance with SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve (SSAP No. 7).

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): While not specific to perpetual bonds, in agenda item 2019-04: SSAP No. 32 – Investment Classification Project, the Working Group has agreed in principle with the accounting for perpetual preferred stock, which from an investor perspective, is materially similar to perpetual bonds.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:
NAIC Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 26R—Bonds to clarify that perpetual bonds shall be reported at fair value, not to exceed any current effective call price. Although this is considered a nonsubstantive change, if a stated effective date is preferred (instead of immediately upon adoption), NAIC staff recommends an effective date of Jan. 1, 2021, with early application permitted. (Although these bonds cannot amortize without a maturity date, NAIC staff notes that the specific reference to fair value may cause a change for reporting entities immediately before year-end. However, it is also noted that these types of bonds are not believed to be overly prevalent.)

SSAP No. 26R – Proposed Updates

Balance Sheet Amount

11. Bonds, as defined in paragraph 3, shall be valued and reported in accordance with this statement, the Purposes and Procedures Manual of the NAIC Investment Analysis Office, and the designation assigned in the NAIC Valuations of Securities product prepared by the NAIC Securities Valuation Office (SVO).

a. Bonds, except for mandatory convertible bonds: For reporting entities that maintain an asset valuation reserve (AVR), the bonds shall be reported at amortized cost, except for those with an NAIC designation of 6, which shall be reported at the lower of amortized cost or fair value. For reporting entities that do not maintain an AVR, bonds that are designated highest-quality and high-quality (NAIC designations 1 and 2, respectively) shall be reported at amortized cost; all other bonds (NAIC designations 3 to 6) shall be reported at the lower of amortized cost or fair value. For perpetual bonds, the bonds shall be reported at fair value regardless of NAIC designation, not to exceed any current effective call price.

b. Mandatory convertible bonds: Mandatory convertible bonds are subject to special reporting instructions and are not assigned NAIC designations or unit prices by the SVO. The balance sheet amount for mandatory convertible bonds shall be reported at the lower of amortized cost or fair value during the period prior to conversion. This reporting method is not impacted by NAIC designation or information received from credit rating providers (CRPs). Upon conversion, these securities will be subject to the accounting guidance of the statement that reflects their revised characteristics. (For example, if converted to common stock, the security will be in scope of SSAP No. 30R—Unaffiliated Common Stock, if converted to preferred stock, the security will be in scope of SSAP No. 32—Preferred Stocks.)
Effective Date and Transition

36. Revisions adopted April 2019, to explicitly exclude securities for which the contract amount of the instrument to be paid at maturity (or the original investment) is at risk for other than failure of the borrower to pay the contractual amount due, are effective December 31, 2019.

36.37. The reporting of perpetual bonds at fair value shall be effective January 1, 2021, with early adoption permitted.

Staff Review Completed by: Jim Pinegar, NAIC Staff – May 2020

Status:
On July 30, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 26R—Bonds, as illustrated above, to clarify that perpetual bonds shall be reported at fair value, not to exceed any current effective call price. Although this is considered a nonsubstantive change, a stated effective date of Jan. 1, 2021, with early application permitted, has been proposed to allow time for reporting entities to make measurement changes as needed.

On November 12, 2020, the Statutory Accounting Principles (E) Working Group exposed revisions to SSAP No. 26R—Bonds, as illustrated below, to clarify that perpetual bonds are within scope as a “bond,” and shall apply the yield-to-worst concept. Additionally, for perpetual bonds that do not possess or no longer possess a call feature shall follow fair value reporting.

SSAP No. 26R – Proposed Updates for the November 12th Interim Meeting:
In conjunction with the NAIC staff recommendation to retain bond accounting (i.e. amortized cost) for perpetual bonds that possess a future call date, however to require fair value accounting for those that do not (or no longer) possess a future call date, the following edits are recommended. All items below are new and have not previously been exposed.

Amortized Cost

9. Amortization of bond premium or discount shall be calculated using the scientific (constant yield) interest method taking into consideration specified interest and principal provisions over the life of the bond FN. Bonds containing call provisions (where the issue can be called away from the reporting entity at the issuer’s discretion), except “make-whole” call provisions, shall be amortized to the call or maturity value/date which produces the lowest asset value (yield-to-worst). Although the concept for yield-to-worst shall be followed for all callable bonds, make-whole call provisions, which allow the bond to be callable at any time, shall not be considered in determining the timeframe for amortizing bond premium or discount unless information is known by the reporting entity indicating that the issuer is expected to invoke the make-whole call provision.

New Footnote: For perpetual bonds with an effective call option, any applicable premium shall be amortized to the next effective call date. For perpetual bonds purchased at a discount, any applicable discount shall be accreted utilizing the yield-to-worst concept.

Balance Sheet Amount

11. Bonds, as defined in paragraph 3, shall be valued and reported in accordance with this statement, the Purposes and Procedures Manual of the NAIC Investment Analysis Office, and the designation assigned in the NAIC Valuations of Securities product prepared by the NAIC Securities Valuation Office (SVO).

a. Bonds, except for mandatory convertible bonds: For reporting entities that maintain an asset valuation reserve (AVR), the bonds shall be reported at amortized cost, except for those with an
On March 15, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to SSAP No. 26R—Bonds, as illustrated below, to clarify that perpetual bonds are within scope. Perpetual bonds with an effective call option shall be amortized under the yield-to-worst concept, whereas perpetual bonds that do not possess, or no longer possess, a call feature shall follow fair value reporting. The adopted revisions included edits discussed during the meeting.

**Adopted Revisions to SSAP No. 26R:**

**Amortized Cost**

9. Amortization of bond premium or discount shall be calculated using the scientific (constant yield) interest method taking into consideration specified interest and principal provisions over the life of the bond. Bonds containing call provisions (where the issue can be called away from the reporting entity at the issuer’s discretion), except “make-whole” call provisions, shall be amortized to the call or maturity value/date which produces the lowest asset value (yield-to-worst). Although the concept for yield-to-worst shall be followed for all callable bonds, make-whole call provisions, which allow the bond to be callable at any time, shall not be considered in determining the timeframe for amortizing bond premium or discount unless information is known by the reporting entity indicating that the issuer is expected to invoke the make-whole call provision.

New Footnote: For perpetual bonds with an effective call option, any applicable premium shall be amortized utilizing the yield-to-worst method.

**Balance Sheet Amount**

11. Bonds, as defined in paragraph 3, shall be valued and reported in accordance with this statement, the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*, and the designation assigned in the NAIC *Valuations of Securities* product prepared by the NAIC Securities Valuation Office (SVO).

c. Bonds, except for mandatory convertible bonds: For reporting entities that maintain an asset valuation reserve (AVR), the bonds shall be reported at amortized cost, except for those with an NAIC designation of 6, which shall be reported at the lower of amortized cost or fair value. For reporting entities that do not maintain an AVR, bonds that are designated highest-quality and high-quality (NAIC designations 1 and 2, respectively) shall be reported at amortized cost; all other bonds (NAIC designations 3 to 6) shall be reported at the lower of amortized cost or fair value. For perpetual bonds in which do not possess or no longer possess an effective call option, the bond shall be reported at fair value regardless of NAIC designation.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

**Issue:** Interpretation Policy Statement Updates

**Check (applicable entity):**

<table>
<thead>
<tr>
<th>Modification of Existing SSAP</th>
<th>P/C</th>
<th>Life</th>
<th>Health</th>
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<tr>
<td>New Issue or SSAP</td>
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<tr>
<td>Interpretation</td>
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**Description of Issue:** This agenda item proposes edits to Appendix F of the *NAIC Policy Statement on Maintenance of Statutory Accounting Principles*, clarifying the requirements regarding the issuance and adoption of accounting interpretations.

**Existing Authoritative Literature:**

*NAIC Policy Statement on Maintenance of Statutory Accounting Principles* (Appendix F) documents the requirements of interpretation issuances and adoptions.

**Development of Interpretations to SSAPs and Referencing Interpretations Within SSAPs**

9. Interpretations will be developed to address, but will not be limited to issues requiring timely application or clarification of existing SAP, which shall not amend, supersede or conflict with existing, effective SSAPs. Issues being considered as an interpretation must be discussed at no less than two open meetings. (Original introduction of the issue when the Working Group identifies the intent to address the issue as an “interpretation” during a public discussion is considered the first open meeting discussion.) The process must allow opportunity for interested parties to provide comments, but as interpretations are intended to provide timely responses to questions of application or interpretation and clarification of guidance, no minimum exposure timeframe is required.

10. The voting requirement to adopt an interpretation is a simple majority. As interpretations do not amend, supersede or conflict with existing SSAP guidance, the interpretation is effective upon Working Group adoption unless specifically stated otherwise. The Working Group shall report the adopted interpretation to the Task Force as part of its public report during the next NAIC national meeting (or earlier if applicable). Interpretations can be overturned, amended or deferred only by a two-thirds majority of the Task Force membership.

11. In rare circumstances, the Working Group may adopt an interpretation which creates new SAP or conflicts with existing SSAPs. Historically, these interpretations temporarily modified statutory accounting principles and/or specific disclosures were developed in response to nationally significant events (e.g., Hurricane Sandy, September 11, 2001). In order to adopt an interpretation that creates new SAP or conflicts with existing SSAPs, the Working Group must have 67% of its members voting (10 out of 15 members) with a super majority (7 out of 10, 8 out of 11 or 12, 9 out of 13, 10 out of 14, or 11 out of 15) supporting adoption. These interpretations can be adopted, overturned, amended or deferred only by a two-thirds majority of the Task Force membership.
12. As new SSAPs are developed, it is essential to review and, if necessary, update the status of interpretations related to SSAPs that are being replaced and/or new SSAPs being developed. The following options are available to the Working Group when a SSAP with existing interpretations is replaced:

   a. **Interpretation of the new SSAP** - If the Working Group would like to maintain the interpretation, the new SSAP can be added to the list of statements interpreted by the interpretation. In addition, the status section of the new SSAP will list the interpretation number next to the heading "Interpreted by."

   b. **Nullification** - When an interpretation is nullified by a subsequent SSAP or superseded by another interpretation, the interpretation is deemed no longer technically helpful, is shaded and moved to Appendix H (Superseded SSAPs and Nullified Interpretations), and the reason for the change is noted beneath the interpretation title. The status section of the SSAP describes the impact of the new guidance and the effect on the interpretation (for example, nullifies, incorporated in the new SSAP with paragraph reference, etc.).

   c. **Incorporation** - When an interpretation is incorporated into a new SSAP, the Working Group can choose from the following two options:

      i. If the interpretation only interprets one SSAP, then the interpretation is listed as being nullified under the "affects" section of the SSAP and is not referenced under the "interpreted by" section of the status page of the SSAP.

      ii. If the interpretation references additional SSAPs, and the Working Group intends to maintain the guidance, the interpretation is unchanged (no nullification). The new SSAP (Summary of Issue section) reflects that the interpretation issue has been incorporated into the new statement.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):** None

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:** None

**Convergence with International Financial Reporting Standards (IFRS):** N/A

**Staff Recommendation:** NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose clarifying revisions to *NAIC Policy Statement on Maintenance of Statutory Accounting Principles* in Appendix F regarding the issuance and adoption of accounting interpretations.

**Development of Interpretations to SSAPs and Referencing Interpretations Within SSAPs**

**Interpretations which DO NOT amend, supersede, or conflict with existing SSAPs**

  9. Interpretations will **may** be developed to address, but will not be limited to issues requiring timely application or clarification of existing SAP, which shall not amend, supersede or conflict with existing, effective SSAPs. Issues being considered as an interpretation must be discussed at no less than two open meetings. (Original introduction of the issue when the Working Group identifies the intent to address the issue as an “interpretation” during a public discussion is considered the first open meeting discussion.) The process must allow opportunity for interested parties to provide comments, but as interpretations are intended to provide timely responses to questions of application or interpretation and clarification of guidance, no minimum exposure timeframe is required.

  10. The voting requirement to adopt an interpretation is a simple majority. As these interpretations do not amend, supersede or conflict with existing SSAP guidance, the interpretation is effective upon Working
Group adoption, unless specifically stated otherwise. The voting requirement to adopt an interpretation of this type is a simple majority. The Working Group shall report the adopted interpretation to the Accounting Practice and Procedures (E) Task Force as part of its public report during the next NAIC national meeting (or earlier if applicable). Interpretations can be overturned, amended or deferred only by a two-thirds majority of the Task Force membership. For clarification, a two-thirds majority of the Task Force requires two-thirds of the entire Task Force membership, not just those electing to vote. Additionally, interpretations can be overturned, amended, deferred, or referred to either the Task Force and/or the Working Group by a simple majority of the Financial Condition (E) Committee.

Interpretations which amend, supersede, or conflict with existing SSAPs

11. In rare circumstances, the Working Group may adopt an interpretation which creates a new SAP or conflicts with existing SSAPs. Historically, these interpretations temporarily modified statutory accounting principles and/or specific disclosures were developed in response to nationally significant events (e.g., Hurricane Sandy, September 11, 2001). In order to adopt an interpretation that creates new SAP or conflicts with existing SSAPs, the Working Group must have 67% of its members voting (10 out of 15 members) with a super majority (7 out of 10, 8 out of 11 or 12, 9 out of 13, 10 out of 14, or 11 out of 15) supporting adoption.

a. These interpretations are effective upon Working Group adoption, unless stated otherwise, and shall be reported to the Accounting Practice and Procedures (E) Task Force as part of its public report during the next NAIC national meeting (or earlier if applicable). In circumstance where the Working Group adopts an interpretation (which creates new SAP or conflicts with existing SSAPs) that is controversial in nature (i.e. due to regulator or industry feedback or could have a policy level impact), the Working Group may elect to postpone the effective date until the item has been discussed by the Task Force and the Financial Condition (E) Committee and both have had an opportunity to review the interpretation.

b. These interpretations can be adopted overturned, amended or deferred by a two-thirds majority of the Task Force membership. For clarification, a two-thirds majority of the Task Force requires two-thirds of entire Task Force membership, not just those electing to vote. Additionally, interpretations can be overturned, amended, deferred, or referred to either the Task Force and/or the Working Group by a simple majority of the Financial Condition (E) Committee.

Staff Review Completed by: Jim Pinegar, NAIC Staff – August 2020

Status:
On November 12, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to NAIC Policy Statement on Maintenance of Statutory Accounting Principles in Appendix F—Policy Statements regarding the issuance and adoption of accounting interpretations, as illustrated above.

On March 15, 2021, the Statutory Accounting Principles (E) Working Group, adopted, as final, revisions to NAIC Policy Statement on Maintenance of Statutory Accounting Principles in Appendix F—Policy Statements in Appendix F—Policy Statements, as illustrated below, regarding the issuance and adoption of accounting interpretations. This adoption included additional revisions to paragraph 11, as discussed during the meeting.

Appendix F – Adopted Revisions:

Development of Interpretations to SSAPs and Referencing Interpretations Within SSAPs

Interpretations which DO NOT amend, supersede, or conflict with existing SSAPs

9. Interpretations will may be developed to address, but will not be limited to, issues requiring timely application or clarification of existing SAP, which shall not amend, supersede or conflict with existing,
effective SSAPs. Issues being considered as an interpretation must be discussed at no less than two open meetings. (Original introduction of the issue when the Working Group identifies the intent to address the issue as an “interpretation” during a public discussion is considered the first open meeting discussion.) The process must allow opportunity for interested parties to provide comments, but as interpretations are intended to provide timely responses to questions of application or interpretation and clarification of guidance, no minimum exposure timeframe is required.

10. The voting requirement to adopt an interpretation is a simple majority. As these interpretations do not amend, supersede or conflict with existing SSAP guidance, the interpretation is effective upon Working Group adoption, unless specifically stated otherwise. The voting requirement to adopt an interpretation of this type is a simple majority. The Working Group shall report the adopted interpretation to the Accounting Practice and Procedures (E) Task Force as part of its public report during the next NAIC national meeting (or earlier if applicable). Interpretations can be overturned, amended or deferred only by a two-thirds majority of the Task Force membership. For clarification, a two-thirds majority of the Task Force requires two-thirds of the entire Task Force membership, not just those electing to vote. Additionally, interpretations can be overturned, amended, deferred, or referred to either the Task Force and/or the Working Group by a simple majority of the Financial Condition (E) Committee.

Interpretations which amend, supersede, or conflict with existing SSAPs

11. In rare certain circumstances such as catastrophes and other time-sensitive issues requiring immediate, temporary statutory accounting guidance, the Working Group may adopt an interpretation which creates a new SAP or conflicts with existing SSAPs. Historically, these interpretations temporarily modified statutory accounting principles and/or specific disclosures were developed in response to nationally significant events (e.g., Hurricane Sandy, September 11, 2001). (Examples of time sensitive issues that have been previously provided INT exceptions to SAP include the transition from LIBOR and special situations such as the federal TALF program.) Interpreations that conflict with existing SSAPs shall be temporary and restricted to circumstances arising from the need to issue guidance for circumstance requiring immediate guidance. In order to adopt an interpretation that creates new SAP or conflicts with existing SSAPs, the Working Group must have 67% of its members voting (10 out of 15 members) with a super majority (7 out of 10, 8 out of 11 or 12, 9 out of 13, 10 out of 14, or 11 out of 15) supporting adoption.

a) These interpretations are effective upon Working Group adoption, unless stated otherwise, and shall be reported to the Accounting Practice and Procedures (E) Task Force as part of its public report during the next NAIC national meeting (or earlier if applicable). In circumstance where the Working Group adopts an interpretation (which creates new SAP or conflicts with existing SSAPs) that is controversial in nature (i.e., due to regulator or industry feedback or could have a policy level impact), the Working Group may elect to postpone the effective date until the item has been discussed by the Task Force and the Financial Condition (E) Committee and both have had an opportunity to review the interpretation.

b) These interpretations can be adopted overturned, amended or deferred by a two-thirds majority of the Task Force membership. For clarification, a two-thirds majority of the Task Force requires two-thirds of entire Task Force membership, not just those electing to vote. Additionally, interpretations can be overturned, amended, deferred, or referred to either the Task Force and/or the Working Group by a simple majority of the Financial Condition (E) Committee.
Statutory Accounting Principles (E) Working Group
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Issue: Clarification of Prescribed Practices

Check (applicable entity):

- Modification of Existing SSAP
- New Issue or SSAP
- Interpretation

P/C  Life  Health

Description of Issue:
This agenda item intends to clarify the definition and application of prescribed practices. This issue has been presented in response to questions received on existing references in the NAIC Accounting Practices & Procedures Manual (AP&P). In summary:

- Each state insurance department has the authority to regulate any insurance company that is licensed in their state. The AP&P Manual is not intended to preempt states’ legislative and regulatory authority.

- The financial statements filed with the NAIC and subject to independent audit, pursuant to Model Law 205: Annual Financial Reporting Model Regulation shall be in accordance with practices prescribed or permitted by the domiciliary state.

- However, in addition to the financial statements required by the domiciliary state, a non-domiciliary state in which the company is licensed may require an insurer to file supplemental financial information that require or allow the use of different accounting practices in the supplementary filing than provided [for] in the AP&P Manual. In the financial statements filed in that state. Ideally, To prevent reporting entities from having to file different financial statements or reports prepared on different basis of accounting with differing states, the practices permitted or prescribed by a domiciliary state will be accepted in all states in which a company is licensed. However, as noted above, the provisions of the AP&P Manual are not intended to preempt states’ legislative or regulatory authority. Accordingly, each state in which a company is licensed could allow or require supplemental financial information that required or allows statutory accounting practices that differ from the AP&P manual and differing financial reports. If a non-domiciliary state in which the company is licensed requires or allows a practice by state statute / bulletin (or other state-wide provision) in such supplemental financial information that is different from NAIC SAP, that practice (s) this provision is also considered a prescribed practice. If the company files financial statements that reflect this practice, even if the financial statements are filed only in the non-domiciliary state, then the prescribed practice disclosure of Note 1 shall apply.

Examples of two possible situations:

**Scenario 1:** Non-domiciliary State A issues a state statute / bulletin that requires the filing of supplemental financial information and which requires the use of an prescribed accounting practice for all companies that are licensed and doing business within State A. Domiciliary State B does not issue a comparable state statute / bulletin.

**Scenario 1 Conclusion:** The reporting entity shall file statutory financial statements with their domiciliary state and the NAIC in accordance with the statutory accounting practices permitted or
prescribed by the domiciliary state (State B). (These financial statements would be subject to the independent audit requirements per Model 205.) The reporting entity also shall file supplemental financial information separate financial statements with State A in accordance with the accounting practice mandated by that non-domiciliary state, but shall also include the prescribed practice disclosure of Note 1 in the supplemental financial information.

**Scenario 2:** Non-domiciliary State A issues a state statute / bulletin that allows an accounting practice for all companies that are licensed and doing business within State A. Domiciliary State B does not issue a comparable state statute / bulletin.

**Scenario 2 Conclusion:** The reporting entity shall file statutory financial statements with their domiciliary state and the NAIC in accordance with the statutory accounting practices permitted or prescribed by the domiciliary state (State B). (These financial statements would be subject to the independent audit requirements per Model 205.) The reporting entity then has the ability, but is not required, to file supplemental financial information statements in State A that reflects the accounting practice prescribed by that non-domiciliary state and shall include the prescribed practice disclosure of Note 1 in the supplemental financial information.

**Existing Authoritative Literature:**

**Preamble**

12. Codification is not intended to preempt state legislative and regulatory authority. While Codification is expected to be the foundation of a state’s statutory accounting practices, it may be subject to modification by practices prescribed or permitted by a state’s insurance commissioner. Statutory financial statements will continue to be prepared on the basis of accounting practices prescribed or permitted by the states. As a result, in 1998 the AICPA’s Insurance Companies Committee determined that it will not be necessary for the Auditing Standards Board to grant the Codification status as an OCBOA since it will not be the sole basis for preparing statutory financial statements. Further, auditors will be permitted to continue to provide audit opinions on practices prescribed or permitted by the insurance department of the state of domicile.

**Preamble Questions and Answers**

**Permitted Practices Advance Notification Requirement – Implementation Questions and Answers**

2. **Q:** What is the difference between a permitted accounting practice and a prescribed practice?

   **A:** **Permitted** accounting practices include practices specifically requested by an insurer that depart from NAIC Statutory Accounting Principles (SAP) and state prescribed accounting practices, as described below, and have received approval from the insurer’s domiciliary state regulatory authority.

   **Prescribed** accounting practices are those practices that are incorporated directly or by reference by state laws, regulations and general administrative rules applicable to all insurance enterprises domiciled in a particular state. The NAIC AP&P Manual is not intended to preempt states’ legislative and regulatory authority.

   If a reporting entity requests an accounting practice that differs from state prescribed accounting practices, but is in accordance with NAIC SAP, advance notice of approval is not required.
The NAIC Model laws do not contain a definition of “prescribed practice,” but references to prescribed practices are noted in the Model laws below. These are provided as reference. There are no revisions proposed to the Model Laws:

Model 205 – Annual Financial Reporting Model Regulation

Section 6 - Designation of Independent Certified Public Accountant

B. The insurer shall obtain a letter from the accountant, and file a copy with the commissioner stating that the accountant is aware of the provisions of the insurance code and the regulations of the Insurance Department of the state of domicile that relate to accounting and financial matters and affirming that the accountant will express his or her opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that Insurance Department, specifying such exceptions as he or she may believe appropriate.

Model 450 – Insurance Holding Company System Model Regulation with Reporting Forms and Instructions

Item 12. Financial Statements and Exhibits

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of the person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of the state.

Model 785 – Credit for Reinsurance Model Law

Section 4. Qualified U.S. Financial Institutions

4.c. Maintains at least $250 million in capital and surplus when determined in accordance with the NAIC Accounting Practices and Procedures Manual, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices; and is.

Model 787 – Term and Universal Life Insurance Reserve Financing Model Regulation

Section 6. The Actuarial Method

B. Valuation used for Purposes of Calculations

For the purposes of both calculating the Required Level of Primary Security pursuant to the Actuarial Method and determining the amount of Primary Security and Other Security, as applicable, held by or on behalf of the ceding insurer, the following shall apply: (1) For assets, including any such assets held in trust, that would be admitted under the NAIC Accounting Practices and Procedures Manual if they were held by the ceding insurer, the valuations are to be determined according to statutory accounting procedures as if such assets were held in the ceding insurer’s general account and without taking into consideration the effect of any prescribed or permitted practices; and
Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None.


Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose proposed revisions to the Preamble Implementation Questions and Answers to clarify prescribed practices. These revisions clarify that while any state in which a company is licensed can issue prescribed practices, the prescribed practices directed by the domiciliary state shall be reflected in the financial statements filed with the NAIC and are the financial statements subject to the independent auditor requirements. (NAIC staff do not believe revisions are necessary to paragraph 12 of the Preamble as that guidance does not limit practices to the domiciliary state and already confirms that the domiciliary state practices shall be reflected in the financial statements subject to audit. For reference paragraph 12 is below.)

12. Codification is not intended to preempt state legislative and regulatory authority. While Codification is expected to be the foundation of a state’s statutory accounting practices, it may be subject to modification by practices prescribed or permitted by a state’s insurance commissioner. Statutory financial statements will continue to be prepared on the basis of accounting practices prescribed or permitted by the states. As a result, in 1998 the AICPA’s Insurance Companies Committee determined that it will not be necessary for the Auditing Standards Board to grant the Codification status as an OCBOA since it will not be the sole basis for preparing statutory financial statements. Further, auditors will be permitted to continue to provide audit opinions on practices prescribed or permitted by the insurance department of the state of domicile.

Proposed Revisions to the Preamble Questions and Answers:

2. Q: What is the difference between a permitted accounting practice and a prescribed practice?

A: **Permitted** accounting practices include practices specifically requested by an insurer that depart from NAIC Statutory Accounting Principles (SAP) and state prescribed accounting practices, as described below, and have received approval from the insurer’s domiciliary state regulatory authority.

**Prescribed** accounting practices are those practices that are incorporated directly or by reference by state laws, regulations and general administrative rules applicable to all insurance enterprises domiciled and/or licensed in a particular state. The NAIC AP&P Manual is not intended to preempt states’ legislative and regulatory authority. **Prescribed accounting practices of the domiciliary state shall be reflected in the statutory financial statements filed with the NAIC. Non-domiciliary states may additionally require insurance entities licensed in their state to file financial statements in accordance with the prescribed accounting practices of that particular non-domiciliary state.**

If a reporting entity requests an accounting practice that differs from state prescribed accounting practices, but is in accordance with NAIC SAP, advance notice of approval is not required.

Staff Review Completed by:
Julie Gann - NAIC Staff
July 2020
**Status:**
On November 12, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed proposed revisions to the Preamble Implementation Questions and Answers to clarify prescribed practices, as illustrated above. These revisions clarify that while any state in which a company is licensed can issue prescribed practices, the prescribed practices directed by the domiciliary state shall be reflected in the financial statements filed with the NAIC and are the financial statements subject to the independent audit requirements.

On March 15, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, revisions to the Preamble Implementation Questions and Answers to clarify prescribed practices, as illustrated below. These revisions clarify that while any state in which a company is licensed can issue prescribed practices, the prescribed practices directed by the domiciliary state shall be reflected in the financial statements filed with the NAIC and are the financial statements subject to the independent audit requirements.

**NAIC staff note:** In addition to the edits proposed to the authoritative guidance, interested parties recommended various edits to the body of this agenda item. While these additional edits do not further modify the authoritative guidance, NAIC staff recognized that agenda items are typically referenced for historical purposes. Accordingly, the additional recommended edits have been reflected and remain shown in the ‘description of issue’ section of this agenda item. These edits clarify the understanding that in addition to the financial statements required by the domiciliary state, a non-domiciliary state in which the company is licensed may require an insurer to file supplemental financial information that require or allow the use of different accounting practices in the supplementary filing than as is required in the AP&P manual.

**Preamble Implementation Questions and Answers Adopted Revisions:**

2. **Q:** What is the difference between a permitted accounting practice and a prescribed practice?

   **A:** **Permitted** accounting practices include practices specifically requested by an insurer that depart from NAIC Statutory Accounting Principles (SAP) and state prescribed accounting practices, as described below, and have received approval from the insurer’s domiciliary state regulatory authority.

   **Prescribed** accounting practices are those practices that are incorporated directly or by reference by state laws, regulations and general administrative rules applicable to all insurance enterprises domiciled and/or licensed in a particular state. The NAIC AP&P Manual is not intended to preempt states’ legislative and regulatory authority. **Prescribed accounting practices of the domiciliary state shall be reflected in the statutory financial statements filed with the NAIC.** Non-domiciliary states may additionally require insurance entities licensed in their state to file supplementary financial information that details the use of different accounting practices required or allowed by the non-domiciliary state that differs from the AP&P Manual.

   If a reporting entity requests an accounting practice that differs from state prescribed accounting practices, but is in accordance with NAIC SAP, advance notice of approval is not required.
Statutory Accounting Principles (E) Working Group
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**Issue:** Related Parties, Disclaimers of Affiliation and Variable Interest Entities

**Check (applicable entity):**

- Modification of existing SSAP
- New Issue or SSAP
- Interpretation

**Description of Issue:**

The intent of this agenda item is to clarify identification of related parties and affiliates in *SSAP No. 25—Affiliates and Other Related Parties* and to incorporate new disclosures to ensure regulators have the full picture of complicated business structures.

The proposed SSAP revisions intend to address the following key aspects:

- Clarify the identification of related parties and ensure that any related party identified under U.S. generally accepted accounting principles (GAAP) or Securities Exchange Commission (SEC) reporting requirements would be considered a related party under statutory accounting principles (SAP).
- Clarify that non-controlling ownership over 10% results in a related party classification regardless of any disclaimer of control or disclaimer of affiliation.
- Clarify the impact of a disclaimer of control or disclaimer of affiliate under SAP. As detailed, such disclaimers impact holding company group allocation and reporting as an SCA under SSAP No. 97, but do not eliminate the classification as a “related party” and the disclosure of material transactions as required under SSAP No. 25.
- Proposes rejection of several U.S. GAAP standards addressing variable interest entities.

NAIC staff noted that the requirements for the SEC filings do not allow for a disclaimer of affiliation, as is allowed in the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation* (#450) and included in Appendix A-440. As a result, the statutory financial statements do not provide the full picture of some complicated business structures, which can be common among insurance companies. This agenda item intends to propose revisions to have the related party and affiliate reporting more closely match that of SEC filings. This will be done by adding language from SEC laws and regulation and clarifying the disclaimer of affiliation or control from a statutory reporting standpoint.

Additionally, this agenda item addresses the FASB Accounting Standards Updates (ASU) related to Variable Interest Entities (VIE) and Consolidation (Topic 810).

FASB defines a VIE as an entity (the investee) in which the investor holds a controlling interest that is not based on the majority of voting rights. This agenda item discusses several ASUs that established the initial guidance for VIEs and all subsequent ASUs to update and clarify this guidance. As a fundamental issue, the concept of consolidation has been rejected for statutory accounting. As such, the main concepts included in the ASUs that are discussed in this agenda item are proposed to be rejected for statutory accounting. While this agenda item is not intended to change the concept of consolidation for statutory accounting, NAIC staff believe that there is a need and justification for enhanced disclosures to supplement the reporting process of related parties and affiliates within...
a company structure. The proposed additions will ensure state insurance regulators have a full picture of the companies that they are regulating.

A brief description of the ASUs that are addressed in this agenda item are included below:

- **ASU 2009-17, Consolidations (Topic 810)—Improvements to Financial Reporting by Enterprises Involved with Variable Interest Entities** clarifies and establishes the basis of U.S. GAAP accounting for consolidation and VIEs. This ASU is a result of *FASB Statement No. 167, Amendments to FASB Interpretation No. 46(R)*.
- **ASU 2010-02, Consolidation (Topic 810)—Accounting and Reporting for Decreases in Ownership of a Subsidiary—a Scope Clarification** addresses implementation issues related to the changes in ownership provisions in Subtopic 810-10, originally issued as *FASB Statement No. 160, Noncontrolling Interests in Consolidated Financial Statements*, which establishes the accounting and reporting guidance for noncontrolling interests and changes in ownership interests of a subsidiary.
- **ASU 2010-10, Consolidations (Topic 810)—Amendments for Certain Investment Funds** defers consolidation requirements for a reporting entity’s interest in an entity that has all the attributes of an investment company or for which it is industry practice to apply measurement principles for financial reporting purposes that are consistent with those followed by investment companies.
- **ASU 2014-07, Consolidation (Topic 810)—Applying Variable Interest Entities Guidance to Common Control Leasing Arrangements** permits a private company lessee (the reporting entity) to elect an alternative not to apply VIE guidance to a lessor entity in certain situations.
- **ASU 2015-02, Consolidation (Topic 810)—Amendments to the Consolidation Analysis** includes updates to limited partnerships and similar legal entities, evaluating fees paid to a decision maker or a service provider as a variable interest, the effect of fee arrangements on the primary beneficiary determination, the effect of related parties on the primary beneficiary determination, and certain investment funds.
- **ASU 2016-17, Consolidation (Topic 810)—Interests Held through Related Parties That Are under Common Control** provides that if a reporting entity satisfies the first characteristic of a primary beneficiary (such that it is the single decision maker of a VIE), these amendments require that reporting entity, in determining whether it satisfies the second characteristic of a primary beneficiary, to include all of its direct variable interests in a VIE and, on a proportionate basis, its indirect variable interests in a VIE held through related parties, including related parties that are under common control with the reporting entity.
- **ASU 2018-17, Consolidation (Topic 810)—Targeted Improvements to Related Party Guidance for Variable Interest Entities** includes updated VIE guidance for private companies and considers if indirect interests held through related parties under common control for determining whether fees paid to decision makers and service providers are variable interests.

**Existing Authoritative Literature:** Statutory accounting guidance is in *SSAP No. 25—Affiliates and Other Related Parties*, model law and regulation provisions are included in *Insurance Holding Company System Regulatory Act (#440)* and the *Insurance Holding Company System Model Regulation (#450)*.

From Model #440

**Section 4. Registration of Insurers**

K. **Disclaimer.** Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or a disclaimer may be filed by the insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclosing the affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the commissioner, within thirty (30) days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall
be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer has been granted by the commissioner, or if the disclaimer is deemed to have been approved.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): In 2010, in response to the issuance of FAS 166, Accounting for Transfers of Financial Assets—an amendment of FASB Statement No. 140 and FAS 167, Amendments to FASB Interpretation No. 46(R), the SAPWG formed the “SAPWG FAS 166/167 Subgroup. FAS 167 was issued in June 2009 and revised the scope of the FASB consolidation guidance to ensure that entities previously considered qualifying special purpose entities were included within the GAAP consolidation. Additionally, FAS 167 requires consolidation for entities (variable interest entities) in which the reporting entity has the “controlling financial interest”. Those situations are specific to when the entity is not controlled by contract, but the reporting entity has: (1) the power to direct the activities of the entity that most significantly impact the entity’s economic performance; and (2) the obligation to absorb losses or receive benefits of the entity that could be potentially significant to the entity. Although the concept of consolidation was not supported for SAP, the Subgroup discussion was focused on considering new disclosures for variable interest entities. The discussion of this Subgroup was deferred as Agenda Item 2011-16, Definition of a Related Party in SSAP No. 25 was considering changes to clarify the relationships that should be considered related parties. Discussion on this agenda item was halted in 2012 and 2015 as FASB issued new ASUs pertaining to VIEs. With the issuance of this new agenda item (2019-34), it is recommended that the 2011 agenda item be disposed.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None


Staff Recommendation:
NAIC Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 25—Affiliates and Other Related Parties, to clarify the types of entities or persons that are included as related parties, to clarify that a non-controlling ownership interest greater than 10% is a related party and is subject to the related party disclosures, to clarify the guidance for disclaimers of affiliation and control for statutory accounting, to clarify that the reporting entity must disclose if they knowingly engaged in any non-arms-length transactions with any entity, individual or company that has not been previously identified as a related party and to reject the seven FASB Accounting Standards Updates listed in the agenda item as not applicable for statutory accounting in SSAP No. 25.

Staff Review Completed by:
Jake Stultz, NAIC Staff – November 2019

Status:
On December 7, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 25—Affiliates and Other Related Parties, to clarify the following:

- The types of entities or persons that are included as related parties;
- That a non-controlling ownership interest greater than 10% is a related party and is subject to the related party disclosures; and
- The guidance for disclaimers of affiliation and control for statutory accounting.
This agenda item also rejects seven FASB Accounting Standards Updates, listed above, for statutory accounting. With exposure, an intent is included to dispose of agenda item 2011-16: Definition of Related Party, which is a historical item drafted to consider the SSAP No. 25 definition. The Working Group also directed notice of the exposure to be sent to the Group Solvency Issues (E) Working Group.

On March 18, 2020, the Statutory Accounting Principles (E) Working Group deferred discussion of this item for a subsequent call or meeting.

**Summer 2020:**
Pursuant to the direction received Dec. 7, 2019, NAIC staff has drafted nonsubstantive revisions to SSAP No. 25. The current version is shown as tracked changes to SSAP No. 25 is attached as an exhibit to this agenda item. The updated draft revisions to SSAP No. 25 are discussed below.

- Based on the comments from the Group Solvency Issues (E) Working Group, NAIC staff have added a new disclosure that provides information on minority ownership interests, as well as significant relationships between minority owners and other U.S. domestic insurers/groups. This new disclosure is not intended to include passive fund owners, such as ETFs and mutual funds. This is in paragraph 22 in the exhibit to this agenda item.
- NAIC staff have removed the direct references to U.S. GAAP and SEC guidance that was included in the initial draft revisions. It was not intended to incorporate by reference the guidance from these sources but was instead intended to show that the revisions were going to be more consistent with the U.S. GAAP and SEC guidance. The language that was added to the description of related parties in paragraph 4 in the original expose draft are all language from either U.S. GAAP or from laws and regulations related to the SEC.
- With the proposed rejection of the U.S. GAAP VIE guidance for statutory accounting, our intention is to rely on SSAP No. 25, including the proposed revisions, to capture related parties for reporting. These updates are not intended to change reporting in Schedule BA or Schedule D for any investments.

On July 30, 2020, the Statutory Accounting Principles (E) Working Group exposed this agenda item, with revisions as detailed above under “Summer 2020.”

On November 12, 2020, the Statutory Accounting Principles (E) Working Group exposed this agenda item, with detailed revisions to SSAP No. 25, as detailed below under “November 12, 2020.”

**November 12, 2020:**
The proposed SSAP revisions intend to address the following key aspects:

- Clarify the identification of related parties and ensure that any related party identified under U.S. GAAP or SEC reporting requirements would be considered a related party under statutory accounting principles.
- Clarify that non-controlling ownership over 10% results in a related party classification regardless of any disclaimer of control or disclaimer of affiliation.
- Clarify the impact of a disclaimer of control or disclaimer of affiliate under SAP. As detailed, such disclaimers impact holding company group allocation and reporting as an SCA under SSAP No. 97, but do not eliminate the classification as a “related party” and the disclosure of material transactions as required under SSAP No. 25.
- Proposes rejection of several U.S. GAAP standards addressing variable interest entities.
On March 15, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions, with modifications to add “direct or indirect’ to paragraphs 4f, 7d, and 8 as discussed during the meeting, to SSAP No. 25—Affiliates and Other Related Parties to address the following key aspects:

- Clarify the identification of related parties and ensure that any related party identified under U.S. GAAP or SEC reporting requirements would be considered a related party under statutory accounting principles.
- Clarify that non-controlling ownership over 10% results in a related party classification regardless of any disclaimer of control or disclaimer of affiliation.
- Clarify the impact of a disclaimer of control or disclaimer of affiliate under SAP. As detailed, such disclaimers impact holding company group allocation and reporting as an SCA under SSAP No. 97, but do not eliminate the classification as a “related party” and the disclosure of material transactions as required under SSAP No. 25.
- Proposes rejection of several U.S. GAAP standards addressing variable interest entities.

The detailed revisions to SSAP No. 25—Affiliates and Other Related Parties are detailed below.
Statement of Statutory Accounting Principles No. 25

Affiliates and Other Related Parties

STATUS

Type of Issue .......................................... Common Area
Issued ...................................................... Initial Draft, November 12, 2020 exposure draft
Effective Date ......................................... January 1, 2001
Affects .................................................... Supersedes SSAP No. 96 with guidance incorporated
Affected by ............................................. August 2011; Nullifies and incorporates INT 03-16
Interpreted by ......................................... No other pronouncements
Relevant Appendix A Guidance ............. A-440

SCOPE OF STATEMENT

1. Related party transactions are subject to abuse because reporting entities may be induced to enter transactions that may not reflect economic realities or may not be fair and reasonable to the reporting entity or its policyholders. As such, related party transactions require specialized accounting rules and increased regulatory scrutiny. This statement establishes statutory accounting principles and disclosure requirements for related party transactions.

2. This statement shall be followed for all related party transactions, including transactions with parties that own 10% or more of the reporting entity, even if the transaction is also governed by other statutory accounting principles. Furthermore, this statement shall be followed in all transactions which involve unrelated parties as intermediaries between related parties. In determining whether a transaction is a related party transaction,
consideration shall be given to the substance of the agreement and the parties whose actions or performance materially impact the insurance reporting entity under the transaction. For example, an investment acquired from a non-related intermediary in which the investment return is predominantly contingent on the performance of a related party shall be considered a related party investment. As a general principle, it is erroneous to conclude that the mere inclusion of a non-related intermediary eliminates the requirement to assess and properly identify the related party transaction in accordance with the provisions of this statement. It is also erroneous to conclude that the presence of non-related assets in a structure predominantly comprised of related party investments eliminates the requirement to assess and identify the investment transaction as a related party arrangement.

3. If a company receives the stock of an affiliated company as a capital contribution rather than through a purchase, the transaction shall be accounted for according to SSAP No. 25—Affiliates and Other Related Parties, SSAP No. 95—Nonmonetary Transactions, or SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, based on the details of each transaction. The statutory purchase method within SSAP No. 68—Business Combinations is not applicable for stock received as a capital contribution.

SUMMARY CONCLUSION

4. Related parties are defined as entities that have common interests as a result of ownership, control, affiliation or by contract. Related parties shall include but are not limited to the following:

a. Affiliates of the reporting entity, as defined in paragraph 5;

b. Trusts for the benefit of employees, such as pension and profit-sharing trusts and Employee Stock Ownership Plans that are managed by or under the trusteeship of management of the reporting entity, its parent or affiliates;

c. The principal owners, directors, officers of the reporting entity;

d. Any immediate family member of a principal owner, director or executive officer of the reporting entity, which means any child, stepchild, parent, stepparent, spouse, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law, or individual related by blood or marriage whose close association is equivalent to a family relationship of such director, executive officer or nominee for director, or any person (other than a tenant or employee) sharing the household of such director, executive officer or nominee for director;

e. Companies and entities which share common control, such as principal owners, directors, or officers, including situations where a principal owners, directors, or officers have a controlling stake in another reporting entity;

f. Any direct or indirect ownership greater than 10% of the reporting entity results in a related party classification regardless of any disclaimer of control or disclaimer of affiliation.

g. The management of the reporting entity, its parent or affiliates (including directors);

h. Members of the immediate families of principal owners and management of the reporting entity, its parent or affiliates and their management;

i. Parties with which the reporting entity may deal if either party directly or indirectly controls or can significantly influence the management or operating policies of the other to an extent that one of the transacting parties might be prevented from fully pursuing its own separate interest;
g. A party which can, directly or indirectly, significantly influence the management or operating policies of the reporting entity, which may include a provider who is contracting with the reporting entity. This is not intended to suggest that all provider contracts create related party relationships;

h-k. A party which has an ownership interest in one of the transacting parties and can significantly influence the other to an extent that one or more of the transacting parties might be prevented from fully pursuing its own separate interests;

i-l. Attorney-in-fact of a reciprocal reporting entity or any affiliate of the attorney-in-fact; and

j-m. A U.S. manager of a U.S. Branch or any affiliate of the U.S. manager of a U.S. Branch.

5. An affiliate is defined as an entity that is within the holding company system or a party that, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the reporting entity. An affiliate includes a parent or subsidiary and may also include partnerships, joint ventures, and limited liability companies as defined in SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies. Those entities are accounted for under the guidance provided in SSAP No. 48, which requires an equity method for all such investments. An affiliate is any person that is directly or indirectly, owned or controlled by the same person or by the same group of persons, that, directly or indirectly, own or control the reporting entity.

6. Control is defined as the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the investee, whether through the (a) ownership of voting securities, (b) by contract other than a commercial contract for goods or nonmanagement services, (c) by contract for goods or nonmanagement services where the volume of activity results in a reliance relationship (d) by common management, or (e) otherwise. Control shall be presumed to exist if a reporting entity and its affiliates directly or indirectly, own, control, hold with the power to vote, or hold proxies representing 10% or more of the voting interests of the entity.

7. Control as defined in paragraph 6 shall be measured at the holding company level. For example, if one member of an affiliated group has a 5% interest in an entity and a second member of the group has an 8% interest in the same entity, the total interest is 13%, and therefore, each member of the affiliated group shall be presumed to have control. This presumption will stand until rebutted by an evaluation of all the facts and circumstances relating to the investment based on the criteria in FASB Interpretation No. 35, Criteria for Applying the Equity Method of Accounting for Investments in Common Stock, an Interpretation of APB Opinion No. 18. The corollary is required to demonstrate control when a reporting entity owns less than 10% of the voting securities of an investee. The insurer shall maintain documents substantiating its determination for review by the domiciliary commissioner. Examples of situations where the presumption of control may be in doubt include the following:

a. Any limited partner investment in a limited partnership, unless the limited partner is affiliated with the general partner.

b. An entity where the insurer owns less than 50% of an entity and there is an unaffiliated individual or group of investors who own a controlling interest.

c. An entity where the insurer has given up participation rights\(^1\) as a shareholder to the investee.

\(^1\) The term "participating rights" refers to the type of rights that allows an investor to effectively participate in significant decisions related to an investee's ordinary course of business and is distinguished from the more limited type of rights referred to as "protective rights". Refer to the sections entitled: “Protective Rights” and “Substantive Participating Rights” in EITF 96-16, Investor's Accounting for an Investee When...
d. Agreements where direct or indirect non-controlling ownership interest is less than 10% where the parties have structured the arrangement in this structure to avoid the 10% threshold in paragraph 4.f. and paragraph 8.

8. Any direct or indirect ownership interest of the reporting entity greater than 10% results in a related party classification regardless of any disclaimer of control or disclaimer of affiliation. The Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation (#450) include a provision that allows for the disclaimer of affiliation and/or the disclaimer of control for members of an insurance holding company system. The disclaimer must be filed with the state insurance commissioner. Entities whose relationship is subject to a disclaimer of affiliation or a disclaimer of control are related parties and are subject to the related party disclosures within this statement. Such a disclaimer does not eliminate a “related party” distinction or disclosure requirements for material transactions pursuant to SSAP No. 25.

8.9. Transactions between related parties must be in the form of a written agreement. The written agreement must provide for timely settlement of amounts owed, with a specified due date. Amounts owed to the reporting entity over ninety days from the written agreement due date shall be nonadmitted, except to the extent this is specifically addressed by other statements of statutory accounting principles (SSAPs). If the due date is not addressed by the written agreement, any uncollected receivable is nonadmitted.

**Related Party Loans**

9-10. Loans or advances (including debt, public or private) made by a reporting entity to its parent or principal owner shall be admitted if approval for the transaction has been obtained from the domiciliary commissioner and the loan or advance is determined to be collectible based on the parent or principal owner’s independent payment ability. An affiliate’s ability to pay shall be determined after consideration of the liquid assets or revenues available from external sources (i.e., determination shall not include dividend paying ability of the subsidiary making the loan or advance) which are available to repay the balance and/or maintain its account on a current basis. Evaluation of the collectibility of loans or advances shall be made periodically. If, in accordance with SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets, it is probable the balance is uncollectible, any uncollectible receivable shall be written off and charged to income in the period the determination is made. Pursuant to SSAP No. 72—Surplus and Quasi-Reorganization, forgiveness by a reporting entity of any debt, surplus note or other obligation of its parent or other stockholder shall be accounted for as a dividend.

10-11. Loans or advances by a reporting entity to all other related parties shall be evaluated by management and nonadmitted if they do not constitute arm’s-length transactions as defined in paragraph 1443. Loans or advances made by a reporting entity to related parties (other than its parent or principal owner) that are economic transactions as defined in paragraph 1443 shall be admitted. This includes financing arrangements with providers of health care services with whom the reporting entity contracts with from time to time. Such arrangements can include both loans and advances to these providers. Evaluation of the collectibility of loans or advances shall be made periodically. If, in accordance with SSAP No. 5R, it is probable the balance is uncollectible, any uncollectible receivable shall be written off and charged to income in the period the determination is made.

11-12. Any advances under capitation arrangements made directly to providers, or to intermediaries that represent providers, that exceed one month’s payment shall be nonadmitted assets.

12-13. Indirect loans are loans or extensions of credit to any person who is not an affiliate, where the reporting entity makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions,
in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the reporting entity making the loans or extensions of credit. The admissibility of indirect loans made by a reporting entity for the benefit of its parent or principal owner shall be determined in accordance with the guidelines in paragraph 109. Indirect loans or advances made for the benefit of all other related parties shall be evaluated and accounted for consistent with loans or advances to related parties as described in paragraph 1110 and paragraph 1211.

Transactions Involving the Exchange of Assets or Liabilities

43-14. An arm’s-length transaction is defined as a transaction in which willing parties, each being reasonably aware of all relevant facts and neither under compulsion to buy, sell, or loan, would be willing to participate. A transaction between related parties involving the exchange of assets or liabilities shall be designated as either an economic transaction or non-economic transaction. An economic transaction is defined as an arm’s-length transaction which results in the transfer of the risks and rewards of ownership and represents a consummated act thereof, i.e., “permanence.” The appearance of permanence is also an important criterion in assessing the economic substance of a transaction. In order for a transaction to have economic substance and thus warrant revenue (loss) recognition, it must appear unlikely to be reversed. If subsequent events or transactions reverse the effect of an earlier transaction prior to the issuance of the financial statements, the reversal shall be considered in determining whether economic substance existed in the case of the original transaction. Subsequent events are addressed in SSAP No. 9—Subsequent Events. An economic transaction must represent a bonafide business purpose demonstrable in measurable terms. A transaction which results in the mere inflation of surplus without any other demonstrable and measurable betterment is not an economic transaction. The statutory accounting shall follow the substance, not the form of the transaction.

44-15. In determining whether there has been a transfer of the risks and rewards of ownership in the transfer of assets or liabilities between related parties, the following—and any other relevant facts and circumstances related to the transaction—shall be considered:

a. Whether the seller has a continuing involvement in the transaction or in the financial interest transferred, such as through the exercise of managerial authority to a degree usually associated with ownership;

b. Whether there is an absence of significant financial investment by the buyer in the financial interest transferred, as evidenced, for example, by a token down payment or by a concurrent loan to the buyer;

c. Whether repayment of debt that constitutes the principal consideration in the transaction is dependent on the generation of sufficient funds from the asset transferred;

d. Whether limitations or restrictions exist on the buyer’s use of the financial interest transferred or on the profits arising from it;

e. Whether there is retention of effective control of the financial interest by the seller.

45-16. A transaction between related parties may meet the criteria for treatment as an economic transaction at one level of financial reporting, but may not meet such criteria at another level of financial reporting. An example of such a transaction is a reporting entity purchasing securities at fair value from an affiliated reporting entity that carried the securities at amortized cost. This transaction meets the criteria of an economic transaction at this level of financial reporting, and therefore, the selling reporting entity would record a gain and the acquiring reporting...
entity would record the securities at their cost (fair value on the transaction date). At the common parent level of reporting, this transaction has resulted in the mere inflation of surplus, and therefore, is a non-economic transaction. The parent reporting entity shall defer the net effects of any gain or increase in surplus resulting from such transactions by recording a deferred gain and an unrealized loss. The deferred gain shall not be recognized by the parent reporting entity unless and until arms-length transaction(s) with independent third parties give rise to appropriate recognition of the gain.

46.17. A non-economic transaction is defined as any transaction that does not meet the criteria of an economic transaction. Similar to the situation described in paragraph 1615, transfers of assets from a parent reporting entity to a subsidiary, controlled or affiliated entity shall be treated as non-economic transactions at the parent reporting level because the parent has continuing indirect involvement in the assets.

47.18. When accounting for a specific transaction, reporting entities shall use the following valuation methods:

a. Economic transactions between related parties shall be recorded at fair value at the date of the transaction. To the extent that the related parties are affiliates under common control, the controlling reporting entity shall defer the effects of such transactions that result in gains or increases in surplus (see paragraph 1645);

b. Non-economic transactions between reporting entities, which meet the definition of related parties above, shall be recorded at the lower of existing book values or fair values at the date of the transaction;

c. Non-economic transactions between a reporting entity and an entity that has no significant ongoing operations other than to hold assets that are primarily for the direct or indirect benefit or use of the reporting entity or its affiliates, shall be recorded at the fair value at the date of the transaction; however, to the extent that the transaction results in a gain, that gain shall be deferred until such time as permanence can be verified;

d. Transactions which are designed to avoid statutory accounting practices shall be reported as if the reporting entity continued to own the assets or to be obligated for a liability directly instead of through a subsidiary.

Examples of transactions deemed to be non-economic include security swaps of similar issues between or among affiliated companies, and swaps of dissimilar issues accompanied by exchanges of liabilities between or among affiliates.

Transactions Involving Services

48.19. Transactions involving services between related parties can take a variety of different forms. One of the significant factors as to whether these transactions will be deemed to be arm’s length is the amount charged for such services. In general, amounts charged for services are based either on current market rates or on allocations of costs. Determining market rates for services is difficult because the circumstances surrounding each transaction are unique. Unlike transactions involving the exchange of assets and liabilities between related parties, transactions for services create income on one party’s books and expense on the second party’s books, and therefore, do not lend themselves to the mere inflation of surplus. These arrangements are generally subject to regulatory approval.
19.20. Transactions involving services provided between related parties shall be recorded at the amount charged\(^2\). Regulatory scrutiny of related party transactions where amounts charged for services do not meet the fair and reasonable standard established by Appendix A-440, may result in (a) amounts charged being recharacterized as dividends or capital contributions, (b) transactions being reversed, (c) receivable balances being nonadmitted, or (d) other regulatory action. Expenses that result from cost allocations shall be allocated subject to the same fair and reasonable standards, and the books and records of each party shall disclose clearly and accurately the precise nature and details of the transaction. See SSAP No 70—Allocation of Expenses for additional discussion regarding the allocation of expenses.

Disclosures

20.21. The financial statements shall include disclosures of all material related party transactions, including transactions with the ownership interests identified in paragraph 22. In some cases, aggregation of similar transactions may be appropriate. Sometimes, the effect of the relationship between the parties may be so pervasive that disclosure of the relationship alone will be sufficient. If necessary to the understanding of the relationship, the name of the related party should be disclosed. Transactions shall not be purported to be arm’s-length transactions unless there is demonstrable evidence to support such statement. The disclosures shall include:

- The nature of the relationships involved;
- A description of the transactions for each of the periods for which financial statements are presented, and such other information considered necessary to obtain an understanding of the effects of the transactions on the financial statements. Exclude reinsurance transactions, any non-insurance transactions which involve less than ½ of 1% of the total admitted assets of the reporting entity, and cost allocation transactions. The following information shall be provided if applicable:
  - Date of transaction;
  - Explanation of transaction;
  - Name of reporting entity;
  - Name of affiliate;
  - Description of assets received by reporting entity;
  - Statement value of assets received by reporting entity;
  - Description of assets transferred by reporting entity; and
  - Statement value of assets transferred by reporting entity.

\(^2\) The amount charged shall be reviewed when there are any modifications or waivers subsequent to the establishment of the contract terms. If waivers or modifications to amounts charged occur, the related party transaction shall be reassessed to determine whether the contract continues to reflect fair and reasonable standards. If the transaction was with a parent or other stockholder and the charge for services has been fully waived, then the guidance in SSAP No. 72 for recognition as contributed capital (forgiveness of reporting entity obligation) or as a dividend (forgiveness of amount owed to the reporting entity) shall apply.
c. The dollar amounts of transactions for each of the periods for which financial statements are presented and the effects of any change in the method of establishing the terms from that used in the preceding period;

d. Amounts due from or to related parties as of the date of each balance sheet presented and, if not otherwise apparent, the terms and manner of settlement;

e. Any guarantees or undertakings, written or otherwise, shall be disclosed in accordance with the requirements of SSAP No. 5R. In addition, the nature of the relationship to the beneficiary of the guarantee or undertaking (affiliated or unaffiliated) shall also be disclosed;

f. A description of material management or service contracts and cost-sharing arrangements involving the reporting entity and any related party. This shall include, but is not limited to, sale lease-back arrangements, computer or fixed asset leasing arrangements, and agency contracts, which remove assets otherwise recordable (and potentially nonadmitted) on the reporting entity’s financial statements;

g. The nature of the control relationship whereby the reporting entity and one or more other enterprises are under common ownership or control and the existence of that control could result in operating results or financial position of the reporting entity significantly different from those that would have been obtained if the enterprises were autonomous. The relationship shall be disclosed even though there are no transactions between the enterprises; and

h. The amount deducted from the value of an upstream intermediate entity or ultimate parent owned, either directly or indirectly, via a downstream subsidiary, controlled, or affiliated entity, in accordance with the Purposes and Procedure Manual of the NAIC Investment Analysis Office, “Procedures for Valuing Common Stocks and Stock Warrants.”

22. The disclosures of ownership interests in the reporting entity shall be provided outside of the financial statements (Schedule Y). The intent of this disclosure is to capture information related to active ownership and is not intended for passive fund owners to be reported.

a. Disclosure is required for all owners with greater than 10% ownership of the reporting entity.

b. Reporting entity must disclose each owner’s ultimate controlling party and must provide a listing of other U.S. insurance groups or entities under that ultimate controlling party’s control.

24-23. Refer to the Preamble for further discussion regarding disclosure requirements.

Relevant Literature

22-24. This statement adopts FASB Statement No. 57, Related Party Disclosures with a modification to paragraph 4 to require disclosure of compensation arrangements, expense allowances, and other similar items in the ordinary course of business.

23-25. This statement rejects ASU 2009-17, Consolidations (Topic 810)—Improvements to Financial Reporting by Enterprises Involved with Variable Interest Entities, ASU 2010-02, Consolidation (Topic 810)—Accounting and Reporting for Decreases in Ownership of a Subsidiary—a Scope Clarification, ASU 2010-10, Consolidations (Topic 810)—Amendments for Certain Investment Funds, ASU 2013-06, Not-For-Profit Entities, Services Received from Personnel of an Affiliate, ASU 2014-07, Consolidation (Topic 810)—Applying Variable Interest Entities Guidance

24.26. Guidance in paragraph 98 was incorporated from SSAP No. 96 as discussed in Issue Paper No. 128—Settlement Requirements for Intercompany Transactions, An Amendment to SSAP No. 25—Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties. SSAP No. 96 was nullified in 2011 with the guidance from that SSAP retained within this SSAP.

Effective Date and Transition

25.27. This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors.

26.28. Guidance reflected in paragraph 98, incorporated from SSAP No. 96, is effective for reporting periods ending December 31, 2007. Early adoption is permitted. A change resulting from the application of this paragraph shall be accounted for as a change in accounting principle in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors. Guidance reflected in paragraph 3, incorporated from INT 03-16: Contribution of Stock, was originally effective December 7, 2003.

REFERENCES

Other

Purposes and Procedures Manual of the NAIC Investment Analysis Office

Relevant Issue Papers

Issue Paper No. 25—Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties

Issue Paper No. 128—Settlement Requirements for Intercompany Transactions, An Amendment to SSAP No. 25—Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties

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Issue: Levelized and Persistency Commission

Check (applicable entity):

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Description of Issue:
NAIC staff has received regulator inquiries on the application of the levelized commissions guidance in SSAP No. 71—Policy Acquisition Costs and Commissions. This agenda item is to recommend clarifications to the existing levelized commissions guidance and provide additional guidance regarding commission that is based on policy persistency. SSAP No. 71 describes that levelized commissions occur in situations in which a third party pays agents non-levelized commissions and the reporting entity pays a third party by levelized payments. The statement notes that it is intended, but not necessarily guaranteed, that the amounts paid to the agents by the third party would ultimately be repaid to the third party from the reporting entity. SSAP No. 71 identifies such arrangements as funding agreements between the reporting entity and the third party. SSAP No. 71 then identifies that the use of a commission arrangement where commission payments are not linked to traditional elements (such as premium payments and policy persistency) requires the establishment of a liability for the full amount of the unpaid principal and accrued interest which is payable to a third party related to levelized commissions is required.

The questions received by NAIC staff relate to the use of levelized commission arrangements and when the liability for commission based on annual persistency is required to be recorded as a liability in accordance with SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets.

Levelized Commission

For the example in question, a third party is paying agent commissions and receiving periodic payments. Consistent with the guidance in SSAP No. 71, paragraph 4, the third party (funding agent) is paying the agents on behalf of the reporting entity and receiving levelized payments from the reporting entity which include additional fees or interest in excess of the commissions. The agreement between the reporting entity and the funding agent specifies that the funding agent will not be reimbursed by the reporting entity if the policies that generate the commission are cancelled prior to the policy anniversary date. The regulator noted that the reporting entity was not accruing the liability to the third-party funding agent, asserting that the payments to the funding agent were theoretically avoidable until the policy had passed the anniversary year-end date.

The accounting issue is whether levelized commission arrangements that are linked to traditional elements (such as premium payments and policy persistency) requires the establishment of a liability for the full amount of the unpaid principal and accrued interest which is payable to a third party related to levelized commissions.

Persistency Commission

Also, in the noted example, the reporting entity was also asserting that the levelized commission obligations related to policy persistency commission were not required to be accrued until the policy anniversary year end had
been passed. The reporting entity asserts that the liability is not required until the persistency commission was fully earned by the agent and therefore unavoidable.

The accounting issue is if the persistency commission expense should be accrued proportionately over the policy period to which the commission relates, or if it is accrued only when fully earned and unavoidable.

Existing Authoritative Literature:

_Preamble_ provides the following (bolding added for emphasis):

37. Liabilities require recognition as they are incurred. Certain statutorily mandated liabilities may also be required to arrive at conservative estimates of liabilities and probable loss contingencies (e.g., interest maintenance reserves, asset valuation reserves, and others).

38. Revenue should be recognized only as the earnings process of the underlying underwriting or investment business is completed. **Accounting treatments which tend to defer expense recognition do not generally represent acceptable SAP treatment.**

_SSAP No. 5 – Revised—Liabilities, Contingencies and Impairments of Assets_

**Liabilities**

2. A liability is defined as certain or probable future sacrifices of economic benefits arising from present obligations of a particular entity to transfer assets or to provide services to other entities in the future as a result of a past transaction(s) or event(s).

3. A liability has three essential characteristics: (a) it embodies a present duty or responsibility to one or more other entities that entails settlement by probable future transfer or use of assets at a specified or determinable date, on occurrence of a specified event, or on demand, (b) the duty or responsibility obligates a particular entity, leaving it little or no discretion to avoid the future sacrifice, and (c) the transaction or other event obligating the entity has already happened. This includes, but is not limited to, liabilities arising from policyholder obligations (e.g., policyholder benefits, reported claims and reserves for incurred but not reported claims). Liabilities shall be recorded on a reporting entity’s financial statements when incurred.

4. Estimates (e.g., loss reserves) are required in financial statements for many ongoing and recurring activities of a reporting entity. The mere fact that an estimate is involved does not of itself constitute a loss contingency. For example, estimates of losses utilizing appropriate actuarial methodologies meet the definition of liabilities as outlined above and are not loss contingencies.

**Loss Contingencies or Impairments of Assets**

6. For purposes of implementing the statutory accounting principles of loss contingency or impairment of an asset described below, the following additional definitions shall apply:
   a. Probable—The future event or events are likely to occur;
   b. Reasonably Possible—The chance of the future event or events occurring is more than remote but less than probable;
   c. Remote—The chance of the future event or events occurring is slight.

7. A loss contingency or impairment of an asset is defined as an existing condition, situation, or set of circumstances involving uncertainty as to possible loss to an enterprise that will ultimately be resolved when one or more future event(s) occur or fail to occur (e.g., collection of receivables).
8. An estimated loss from a loss contingency or the impairment of an asset shall be recorded by a charge to operations if both of the following conditions are met:

a. Information available prior to issuance of the statutory financial statements indicates that it is probable that an asset has been impaired or a liability has been incurred at the date of the statutory financial statements. It is implicit in this condition that it is probable that one or more future events will occur confirming the fact of the loss or incurrence of a liability; and

b. The amount of loss can be reasonably estimated.

**SSAP No. 71—Policy Acquisition Costs and Commissions** provides the following (bolding added for emphasis):

**SUMMARY CONCLUSION**

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

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

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

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

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):** None

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:** None

**Convergence with International Financial Reporting Standards (IFRS):** Not applicable
Staff Review Completed by:
Robin Marcotte, NAIC Staff – July 2019

Staff Recommendation:
NAIC Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 71 as illustrated below. NAIC Staff recommends that revisions to the guidance clarify the following:

1. A levelized commission arrangement (whether linked to traditional or nontraditional elements) require the establishment of a liability for the full amount of the unpaid principal and accrued interest payable to a third party at the time the policy is issued.

2. The persistency commission is accrued proportionately over the policy period in which the commission relates to and is not deferred until fully earned.

These recommendations are consistent with the original intent of SSAP No. 71 as well as the Statutory Statement of Concepts focusing on Recognition (excerpts from Preamble, paragraphs 37 and 38):

- Liabilities require recognition as they are incurred.
- Accounting treatments which tend to defer expense recognition do not generally represent acceptable SAP treatment.

July 2019 Proposed Revisions to SSAP No. 71:

SUMMARY CONCLUSION

2. Acquisition costs are those costs that are incurred in the acquisition of new and renewal insurance contracts and include those costs that vary with and are primarily related to the acquisition of insurance contracts (e.g., agent and broker commissions, certain underwriting and policy issue costs, and medical and inspection fees). Acquisition costs and commissions shall be expensed as incurred. Determination of when acquisition costs and commissions have been incurred shall be made in accordance with SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets. The recognition of commission expense for new and renewal insurance contracts meets the definition of a liability under SSAP No. 5R when the policy is issued or renewed. The issuance of the policy is the obligating event under SSAP No. 5R.

3. Contingent commission liabilities shall be determined in accordance with the terms of each individual commission agreement. Commission liabilities determined on the basis of a formula that relates to loss experience shall be established for the earned portion. Assumptions used to calculate the contingent commission liability shall be consistent with the terms of the policy contract and with the assumptions made in recording other assets and liabilities necessary to reflect underwriting results of the reporting entity such as retrospective premium adjustments and loss reserves, including incurred but not reported. Commission contracts that include persistency (or other such components) shall not use these clauses to defer recognition of commission expense. If a commission is based on annual policy persistency (or similar components), the commission is accrued based on experience to date for the policy period (it is inappropriate to wait until the amount is fully earned and/or unavoidable). Actual policy cancellation would reverse the accrual of the related persistency commission.

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

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

New Footnote – The guidance in this paragraph does not imply that levelized commissions that are linked to traditional elements do not require establishment of a liability. Rather, such levelized commissions are captured in paragraphs 3-4.

Status:
On August 3, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 71—Policy Acquisition Costs and Commissions, as illustrated above, to clarify levelized commissions guidance and provide additional direction regarding commissions that are based on policy persistency. The revisions also clarify that the recognition of commission expense is based on experience to date.

For Fall 2019 Discussion NAIC staff has proposed updates for exposure.

Paragraph 2 - Removed previously exposed revisions as unneeded.
Paragraph 3 - Added clarifying phrases regarding persistency commission accrual. The concept is that normal persistency commission is accrued for the period it relates to unless the policy is cancelled.
Paragraph 4 - Added two clarifying phrases to assist with identifying levelized commission funding agreements.
Paragraph 5 - Added clarifying phrases regarding funding agreements.
Footnote 1 - Redrafted to remove double negative wording.

Fall 2019 Proposed Revisions to SSAP No. 71:

SUMMARY CONCLUSION

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

3. Contingent commission liabilities shall be determined in accordance with the terms of each individual commission agreement. Commission liabilities determined on the basis of a formula that relates to loss experience shall be established for the earned portion. Assumptions used to calculate the contingent commission liability shall be consistent with the terms of the policy contract and with the assumptions made in recording other assets and liabilities necessary to reflect underwriting results of the reporting entity such as retrospective premium adjustments and loss reserves, including incurred but not reported. Commission contracts that include persistency (or other such components) shall not use these clauses to defer recognition of commission expense. If a commission is based on annual policy
Persistency (or other similar components), the commission shall be accrued based on experience to date for the policy period that the commission relates. In regard to persistency commission, it is inappropriate to wait until the amount is fully earned and/or unavoidable to accrue experience to date commission expenses. Actual policy cancellation would reverse the accrual of the related persistency commission.

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

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

New Footnote – The guidance in this paragraph notes that levelized commissions which use a third party to pay agents that are linked to traditional elements require establishment of a liability for the amounts that have been paid to the agents and any interest accumulated to date.

On December 7, 2019, the Statutory Accounting Principles (E) Working Group exposed revisions to SSAP No. 71—Policy Acquisition Costs and Commissions, as illustrated above, to include additional NAIC staff modifications regarding persistency commission and levelized commission arrangements to address certain comments received and to allow for further discussion. With this exposure, the Working Group directed a notification of the exposure to be sent to the Life Actuarial (A) Task Force.

On March 18, 2020, the Statutory Accounting Principles (E) Working Group deferred discussion of this item for a subsequent call or meeting.

On July 30, 2020, the Statutory Accounting Principles (E) Working Group exposed revisions to SSAP No. 71—Policy Acquisition Costs and Commissions, as illustrated below. Exposed revisions clarify existing levelized commissions guidance which requires full recognition of the funding liabilities incurred to date for commission expenses prepaid on behalf of an insurer. The exposed revisions are consistent with the 2019 Fall National Meeting exposure, with the inclusion of guidance to clarify that reporting entities that have not complied with the original intent shall reflect the change as a correction of an error, in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors, in the year-end 2020 financial statements.

July 30, 2020 Exposed Revisions to SSAP No. 71:

SUMMARY CONCLUSION

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

3. Contingent commission liabilities shall be determined in accordance with the terms of each individual commission agreement. Commission liabilities determined on the basis of a formula that relates to loss experience shall be consistent with the terms of the policy contract and with the assumptions made in recording other assets and liabilities necessary to reflect underwriting results of the reporting entity such as retrospective premium adjustments and loss reserves, including incurred but not reported. Commission contracts that include persistency (or other such components) shall not use these clauses to defer recognition of commission expense. If a commission is based on annual policy persistency (or other similar components), the commission shall be accrued based on experience to date for the policy period that the commission relates. In regard to persistency commission, it is inappropriate to wait until the amount is fully earned and/or unavoidable to accrue experience to date commission expenses. Actual policy cancellation would reverse the accrual of the related persistency commission.

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

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

New Footnote – The guidance in this paragraph notes that levelized commissions which use a third party to pay agents that are linked to traditional elements require establishment of a liability for the amounts that have been paid to the agents and any interest accumulated to date.

Effective Date and Transition

7. This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors. The nonsubstantive revisions adopted regarding levelized commission intend to clarify the original intent of this statement. Reporting entities that have not complied with the original intent of the statement shall reflect the change as a correction of an error (as a mistake in the application of an accounting principle) pursuant to SSAP No. 3 in the December 31, 2020 financial statements. In accordance with SSAP No. 3, correction of all accounting errors in previously issued financial statements, for which an amended financial statement was not filed, shall be reported as an adjustment to unassigned funds (surplus) in the period in which the error was detected. Disclosure shall also occur in accordance with SSAP No. 3.
On October 15, 2020, the Statutory Accounting Principles (E) Working Group held a hearing to receive comments, resulting in updated exposed revisions to SSAP No. 71—Policy Acquisition Costs and Commissions, as illustrated below. The updated exposed revisions clarify existing levelized commissions guidance, which requires full recognition of funding agreement liabilities incurred for commission expenses obligated when an insurance policy is written. (This guidance clarifies that writing the insurance policy is the obligating event for initial sales commission.) The exposed revisions have the following key changes from the prior exposure:

1. Improved description of the funding agreements in paragraphs 4 and 5.
2. Deletes the previously proposed revisions in paragraph 3 regarding other types of commission to address the comments received regarding unintended impacts on traditional renewal commission.
3. Modifies the revisions in paragraph 7 to remove the language on correction of an error.
4. Proposes the nonsubstantive revisions apply to contracts in effect on Jan. 1, 2021.

For ease of review the following pages illustrate the October 15, 2020 exposed revisions in two formats:

1. Exposure reflecting tracked revisions to Existing SSAP No. 71
2. October 2020 (new) Shaded Revisions to prior July exposure

Oct. 2020 Exposure of Tracked Revisions to Existing SSAP No. 71

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

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

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

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

Effective Date and Transition

7. This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors. The nonsubstantive revisions adopted regarding levelized commission are to clarify the original intent of this statement and are effective January 1, 2021.
October 2020 (new) Shaded Revisions to prior July exposure

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

3. Contingent commission liabilities shall be determined in accordance with the terms of each individual commission agreement. Commission liabilities determined on the basis of a formula that relates to loss experience shall be established for the earned portion. Assumptions used to calculate the contingent commission liability shall be consistent with the terms of the policy contract and with the assumptions made in recording other experience shall be established for the earned portion. Assumptions used to calculate the contingent commission are set at the time of the commission agreement. Commission liabilities determined on the basis of a formula that relates to loss experience shall be accrued based on experience to date for the policy period that the commission relates. In regard to persistency the commission, it is inappropriate to wait until the amount is fully earned and/or unavoidable to accrue experience to date commission expenses. Actual policy cancellation would reverse the accrual of the related persistency commission.

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

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

7. This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors. The nonsubstantive revisions adopted regarding levelized commission intend are to clarify the original intent of this statement and are effective January 1, 2021. Reporting entities that have not complied with the original intent of the statement shall reflect the change as a correction of an error (as a mistake in the application of an accounting principle) pursuant to SSAP No. 3 in the December 31, 2020 financial statements. In accordance with SSAP No. 3, correction of all accounting errors in previously issued financial statements, for which an amended financial statement was not filed, shall be reported as an adjustment to unassigned funds (surplus) in the period in which the error was detected. Disclosure shall also occur in accordance with SSAP No. 3.

On November 12, 2020, the Statutory Accounting Principles (E) Working Group held a hearing to receive comments. The Working Group took the following actions:

- **Re-exposed** the prior version of SSAP #71 with shaded edits reflected below. – (1) the proposed effective date of Jan.1, 2021 was changed to be effective upon adoption, and (2) the revised text made explicit that the proposed revisions will apply to contracts in effect as of the date of adoption. Comments due by Jan. 11, 2021.

- **Determined that the revisions to SSAP #71 had met the due process for either a substantive or a non-substantive revision but concluded to keep the revision classified as nonsubstantive.** The Working Group reiterated that it is not the impact of a change on an individual entity that determines whether a change is substantive or non-substantive, but whether the revision is in line with the original intent of the SSAP. The Working group noted that this is a clarification of existing guidance consistent with original intent. Commissioner Donelon noted an objection to the classification as non-substantive.

- **Directed NAIC Staff to draft an Issue Paper** to document the discussion on this topic for historical purposes. The issue paper will be exposed for comment before considered for adoption by the Working Group.

**Nov. 12, 2020 Exposed shaded SSAP No. 71 revisions are new from prior exposure.**

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

3. **Contingent commission liabilities shall be determined in accordance with the terms of each individual commission agreement. Commission liabilities determined on the basis of a formula that relates to loss experience shall be established for the earned portion. Assumptions used to calculate the contingent commission liability shall be consistent with the terms of the policy contract and with the assumptions made in recording other assets and liabilities necessary to reflect underwriting results of the reporting entity such as retrospective premium adjustments and loss reserves, including incurred but not reported.**
4. Levelized commissions occur in situations where agents receive normal (non-level) commissions with payments made by a third party. It is intended, but not necessarily guaranteed, that the amounts paid to the agents by the third party would ultimately be repaid (with interest explicit or implied) to the third party by levelized payments (which are less than the normal first year commissions but exceed the normal renewal commissions) from the reporting entity. (Note: levelized repayments made by the reporting entity extend the repayment period but might not be a straight-line repayment.) These transactions are, in fact, funding agreements between a reporting entity and a third party, regardless of how the payment to the third party is characterized. The continuance of the stream of payments specified in the levelized commission contract is a mechanism which attempts to bypass recognition of those expenses which are ordinarily charged to expense in the first year of the contract. Consequently, the normal link between the persistency of the policy, the continuance of the premium payment or the maintenance of the agent's license with the reporting entity is not maintained with respect to the payment stream.

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

Effective Date and Transition

7. This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors. The nonsubstantive revisions adopted TBD date regarding levelized commission are to clarify the original intent of this statement and apply to existing contracts are effective in effect on the date of adoption of the revisions January 1, 2021.
For Spring 2021 discussion, NAIC staff recommend that the Working Group take the following actions:

1. **Expose the issue paper to document the historical discussion.**

2. **Adopt the exposed revisions to SSAP No. 71 after discussion regarding whether to incorporate the revisions to paragraph 7 regarding the effective date** which is illustrated as shaded text below. The November 2020 exposure was for the revisions to be effective on adoption. This is because some members noted a preference for an early as possible effective date in 2021. Guggenheim and IPs comments requested an effective date no sooner than December 31, 2021 to allow time to work with regulators, auditors etc.

   In the event that the Working Group wants to consider the industry request, NAIC staff has provided language for a December 31, 2021 effective date as illustrated below. As the issue paper is to document the historical discussion there is not a need to delay the effective date for an issue paper that is not authoritative. A December 31, 2021 effective date would allow the issue paper to be adopted prior to the implementation of the revisions. Note that under SSAP No. 3, the impacts are still calculated using Jan. 1 numbers, but would not be initially reported until the year-end 2021 financial statements.

   **Effective Date and Transition (shaded revisions to paragraph 7 are for discussion).**

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

3. **Note – It is recommended that the Working Group expose a blanks proposal (2021-04BWG, see attachment 20.1) to incorporate a new general interrogatory to assist with identifying the use of funding agreements** as a concurrent exposure with the Blanks (E) Working Group. This general interrogatory will require the identification of circumstances of when an insurer utilizes third parties to pay agent commissions in which the advances paid by the 3rd party are not settled in full within 90 days. The 90-day threshold for reporting was selected to not require reporting when an insurer a third-party for traditional payment processing. This proposal is attached at 20.1 and was developed with Working Group member input. (Staff Note: Input from interested parties is requested to ensure that this GI is written to capture the desired information on companies using financing arrangements to pay commissions.)

**SSAP No. 71 Nov. 12, 2020 exposure with shaded revisions to paragraph 7 for Spring 2021 discussion**

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

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

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

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

Effective Date and Transition

7. This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors. The nonsubstantive revisions adopted TBD date regarding levelized commission are to clarify the original intent of this statement and apply to existing contracts in effect as of December 31, 2021 and new contracts thereafter on the date of adoption of this statement.
interrogatory to identify certain situations where an insurer utilizes a third-party for the payment of commission expenses. The blanks proposal will be concurrently exposed with the Blanks (E) Working Group exposure.

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

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

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

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

5. The use of an arrangement such as a levelized commission arrangement where commission payments are not linked to traditional elements such as premium payments and policy persistency, but rather are linked to the repayment of an advance amount paid by a third party to the direct selling agents requires the establishment of a liability by the reporting entity for the full amount of the unpaid principal and accrued interest which is payable to a third party related to levelized commissions. Arrangements that use a third party to pay agents who write policies for the reporting entity and the insured can be an attempt to de-link the relationship between the insurer and those agents and defer or levelize the acquisition commissions. The insurance reporting entity is required to recognize the full amount of earned commission costs to the direct policy writing agents even if those costs are paid indirectly to the agents by a third party through the use of levelized commission, or similar arrangement, which is in substance a funding arrangement. Having a third party pay commission costs to the selling agent is strong evidence of a potential funding arrangement which shall be recognized as a liability because the substance of the arrangement indicates that repayment is reasonable and probable, even if a contingency has been incorporated into the funding arrangement, until the underlying policy has been cancelled. A third-party structure cannot recharacterize (e.g. by referencing policy persistency) and delay recognition of liabilities for initial sales commission owed from the writing of policies regardless of how a third-party arrangement is structured with regards to the timing of payment from the insurer. The amount owed for full initial sales commission shall be recognized immediately as the writing of an insurance contract is the event that obligates the insurer, and such action shall occur consistently among insurers. As such, this recognition is required regardless of if the insurer owes a selling agent directly or if a third-party has been contracted to provide payment to the selling agent.
Effective Date and Transition
7. This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors. The nonsubstantive revisions adopted March 15, 2021 regarding levelized commission are to clarify the original intent of this statement and apply to existing contracts in effect as of December 31, 2021 and new contracts thereafter.
The Blanks (E) Working Group of the Accounting Practices and Procedures (E) Task Force met March 16, 2021. The following Working Group members participated: Jake Garn, Chair (UT); Kim Hudson, Vice Chair (CA); William Arfanis (CT); N. Kevin Brown (DC); Rylynn Brown and Tom Hudson (DE); Carolyn Morgan (FL); Daniel Mathis (IA); Roy Eft (IN); Dan Schaefer (MI); Debbie Doggett (MO); Lindsay Crawford and Justin Schrader (NE); Patricia Gosselin (NH); Nakia Reid (NJ); Dale Bruggeman and Tracy Snow (OH); Diane Carter (OK); Kimberly Rankin (PA); Trey Hancock (TN); Shawn Fredrick (TX); Steve Drutz (WA); Randy Milquet (WI); and Jamie Taylor (WV).

1. **Adopted its Dec. 16 Minutes**

   The Working Group met Dec. 16 and adopted four proposals. Among these was: 1) removing the disclosure for the federal Affordable Care Act (ACA) Section 9010 Assessment from Note 22 – Events Subsequent; 2) removing the line category and reference to the NAIC Bond Fund List (Bond List) from the investment schedule instructions and blank; 3) moving the interrogatory question regarding Communication of Internal Control Related Matters Noted in Audit from the annual Supplemental Exhibits and Schedules Interrogatories to the quarterly Supplemental Exhibits and Schedules Interrogatories to be answered for the second quarter. For title, a new page in the quarterly statement is added for the Supplemental Exhibits and Schedules Interrogatories; and 4) replacing the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation and the Adjustments to the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibits with modernized exhibits. The Working Group exposed seven proposals for a 60-day public comment period ending Feb. 16, 2021. The Working Group also adopted its editorial listing.

   Ms. Crawford made a motion, seconded by Mr. Hudson, to adopt the Working Group’s Dec. 16 minutes (Attachment Two-A). The motion passed unanimously.

2. **Adopted Proposals Previously Exposed**

   a. **Agenda Item 2020-32BWG – Effective Dec. 31, 2021**

      Mr. Garn stated that this proposal adds a new Exhibit 3 and Exhibit 3A Health Care Receivables Supplement to the life/fraternal annual statement. It adds a reference to the guidance document posted as part of the health annual statement health care receivables (HCR) reporting. He stated that there were no interested party comments received.

      Mr. Arfanis made a motion, seconded by Mr. Snow, to adopt the proposal (Attachment Two-B). The motion passed unanimously.

   b. **Agenda Item 2020-33BWG – Effective Jan. 1, 2022**

      Mr. Schrader stated that this proposal modifies the annual statement lines used in the Underwriting and Investment Exhibits, the Exhibit of Premiums and Losses (State Page) and the Insurance Expense Exhibit (IEE) for consistency throughout the property/casualty (P/C) blank. The proposal changes the health line categories used in the property blank to be consistent with other statement types. The lines were updated in the crosscheck references and in the definitions section of the instructions.

      The effective date has been changed to first-quarter 2022 at the suggestion of interested parties for consistency between the annual filings and quarterly statement filings. The size issue referenced by interested parties has also been resolved. Interested parties requested changes to Schedule H to be consistent with the changes being made in this proposal. NAIC staff have been working on another Schedule H proposal and will incorporate these suggestions as well to be presented for exposure in the near future. He stated that the modifications are highlighted within the proposal document.

      Mr. Schrader made a motion, seconded by Mr. Milquet, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Schrader made a motion, seconded by Mr. Milquet, to adopt the modified proposal (Attachment Two-C). The motion passed unanimously.
c. **Agenda Item 2020-34BWG – Effective Dec. 31, 2021**

Mr. Garn stated that this proposal includes a change to the P/C blank only. It adds additional definitions for occupational accident, fiduciary liability, premises and operations (OL&T and M&C), professional errors and omissions liability, kidnap and ransom liability, and tuition reimbursement plans products to the appropriate line of business in the appendix of the annual statement instructions. He stated that there were no interested party comments received for this proposal.

Mr. Hudson made a motion, seconded by Mr. Drutz, to adopt the proposal (Attachment Two-D). The motion passed unanimously.

d. **Agenda Item 2020-35BWG – Effective Jan. 1, 2022**

Mr. Hudson stated that this proposal expands the number of line characters used from seven to 10 in the investment categories for Schedules D, DA, DL and E, excluding Schedule D, Part 6, Section 1 and Section 2 and Schedule E, Part 1 and Part 3. It adds line categories for Unaffiliated Certificates of Deposit and Exchange Traded Funds (ETFs). It splits the line categories for Mutual Funds, Investment Unit Trusts and Closed-End Funds into lines indicating if the fund has been assigned a designation by the Securities Valuation Office (SVO). It makes changes to the Summary Investment Schedule, the Summary by Country and Schedule D, Part 1A, Section 1 and Section 2 to reflect the additional line categories. He stated that the purpose of this change is to accommodate more line categories and to allow for room in the numbering scheme for Schedules D, DA, DL and E to add additional lines in the future without major disruption of line numbering. It also adds new lines to address crosscheck issues and reporting questions that have been received in the past. Interested parties made some editorial corrections and suggestions, which are highlighted in the proposal.

Mr. Hudson made a motion, seconded by Ms. Gosselin, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Hudson made a motion, seconded by Ms. Gosselin, to adopt the modified proposal (Attachment Two-E). The motion passed unanimously.

e. **Agenda Item 2020-36BWG – Effective Dec. 31, 2021**

Mr. Bruggeman stated that this agenda item reflects actions taken by the Statutory Accounting Principles (E) Working Group on March 15. The Working Group adopted its agenda item 2020-33, which provides a change in Statement of Statutory Accounting Principles (SSAP) for publicly traded preferred stock warrants. He stated that in general, warrants are in the scope of SSAP No. 86—Derivatives. However, there is a special carveout for publicly traded common stock warrants. They are in the scope of SSAP No. 30R—Unaffiliated Common Stock. With the only difference between the two instruments being the type of security one receives (i.e., public or common stock), the Working Group elected a similar carveout for publicly traded preferred stock warrants. This blanks proposal modifies the instructions for both the General Investment Schedules and for Schedule DB to reflect this change. He stated that interested parties did not have any comments on this proposal. (SAPWG Ref #2020-33.)

Mr. Bruggeman made a motion, seconded by Ms. Brown, to adopt the proposal (Attachment Two-F). The motion passed unanimously.

f. **Agenda Item 2020-37BWG – Effective Dec. 31, 2021**

Mr. Bruggeman stated that this agenda item reflects actions taken on March 15 by the Statutory Accounting Principles (E) Working Group regarding its agenda item 2019-34. In collaboration with interested parties, the Working Group adopted additional related party disclosure elements, specifically to capture instances where an entity, either directly or indirectly, owns greater than 10% of a reporting entity. While the Statutory Accounting Principles (E) Working Group agenda item clarified that ownership greater than 10% results in a related party classification, regardless of any disclaimer of control of affiliation, the blanks item proposed a new Schedule Y, Part 3 to data capture items such as owners with more than 10% and identification of an insurer’s ultimate controlling party. During this last Blanks (E) Working Group exposure, interested parties commented that terms of “ultimate controlling party” and “ultimate controlling entity(ies)/person(s)” were not being consistently referenced. The Statutory Accounting Principles (E) Working Group confirmed that in model laws Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450), the terms are used interchangeably. Since this change was not made prior to the posting of materials, Mr. Bruggeman stated that he agrees with incorporating a notation in the instructions to indicate that the two terms, “ultimate controlling party” and “ultimate controlling entity(ies)/person(s),” may be used interchangeably. (SAPWG Ref #2019-34.)
Mr. Bruggeman made a motion, seconded by Mr. Hancock, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Bruggeman made a motion, seconded by Mr. Hancock, to adopt the modified proposal (Attachment Two-G). The motion passed unanimously.

g. Agenda Item 2020-38BWG – Effective Dec. 31, 2021 (State Data Reporting Requirement Effective Dec. 31, 2022)

Mr. Garn stated that this proposal makes changes to the Accident and Health Policy Experience Exhibit, adding new columns, removing the lines “with and without contract reserves” in the individual section, and adding some new product lines. The summary tables are being eliminated; since reinsurance has been incorporated into the main exhibit, the summary tables are no longer needed. The proposal changes the reporting due date to a March 1 filing and requests the data to be reported by state. Interested parties requested the reporting date to remain as an April 1 filing. This modification, along with some editorial suggestions made by interested parties, has been incorporated into the proposal. Mr. Garn stated that the effective date of the state reporting will be annual 2022.

Tip Tipton (Thrivent Financial) stated that interested parties agree with the filing date of April 1 for the supplement, as well as deferring the reporting of state information until annual 2022.

Mr. Eft made a motion, seconded by Ms. Rankin, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Eft made a motion, seconded by Mr. Hudson, to adopt the modified proposal (Attachment Two-H). The motion passed unanimously.

3. Exposed New Items

a. Agenda Item 2021-01BWG

Mr. Drutz stated that this proposal adds a reference to health care receivables in line 24 – Health Care and Other Amounts Receivable on the Assets page. It changes the description of line 0699999 to read Other Health Care Receivables on Exhibit 3 and modify column headers for Exhibit 3A. He stated that the Health Risk-Based Capital (E) Working Group continues to study health care receivables data. However, the reported data did not appear to be accurate. This change is intended to provide clarifying instructions to gain accuracy and consistency in the reporting of health care receivables.

Hearing no objection from the Working Group, the proposal was exposed with a 6-week public comment period ending April 27.

b. Agenda Item 2021-02BWG

Dan Daveline (NAIC) stated he is staff support for the Group Capital Calculation (E) Working Group, sponsor of this proposal. The purpose of this proposal is to obtain greater information relating to insurers that are regulated by the Federal Reserve System (FRS) and to gain consistent terminology with that used by the FRS. Regarding the terminology, one example is replacing the “holding company” with “depository institution holding company.” Mr. Daveline said to ensure that the entire population of such groups is picked up, the Group Capital Calculation (E) Working Group is proposing two distinct questions, 8.5 and 8.6, to identify the different types of groups likely to be subject to the Federal Reserve Group Capital, also known as the BBA. Mr. Daveline stated that these entities are not required to file the GCC. Having this more granular information will be helpful to the lead states of those groups. Having current information will also help in addressing questions that the Working Group and NAIC staff often receive from NAIC members about the insurers subject to regulation by the FRS.

Hearing no objection from the Working Group, the proposal was exposed with a 6-week public comment period ending April 27.

c. Agenda Item 2021-03BWG

Mr. Bruggeman stated that this agenda item is in response to the Statutory Accounting Principles (E) Working Group items 2020-37 and 2020-38. This proposal increases the reporting granularity in the Separate Accounts General Interrogatories, specifically for interrogatory questions 1.01, 1.01A, 2.5 and 4.2. In response to the recent and extensive growth of pension risk transfer (PRT) transactions and registered indexed linked annuity (RILA) products, state insurance regulators sought a method to more readily identify PRT transactions and RILA product features, reserves and the extent they pose a potential risk to the
general account. From review of the 2019 separate account blanks, it was found that most separate account products were grouped into three or four broad categories. Thus, they were not very detailed when it came to specific product identification. This proposal adds separate and distinct reporting product identifiers for RILA products and PRT transactions, and the instructions to the general interrogatories have been slightly modified to require a disaggregated product identifier for each product represented. With that said, aggregation in reporting can still occur if the products are under the same product filing or policy form. However, to the extent they are not, it would require disaggregated reporting. A couple of additional notes: 1) the distinct product identifier requirements have been a long-standing instruction. However, most reporting entities have been grouping or aggregating reporting. This instruction change simply requires further detailed reporting; and 2) the proposal also includes instructions so that a company may eliminate proprietary or confidential information, but still require a unique reporting product identifier.

Hearing no objection from the Working Group, the proposal was exposed with a 6-week public comment period ending April 27.

d. Agenda Item 2021-04BWG

Mr. Bruggeman stated that this proposal is related to the Statutory Accounting Principles (E) Working Group agenda item 2019-24 regarding levelized commission guidance in SSAP No. 71—Policy Acquisition Costs and Commissions. This proposal was in response to state insurance regulators having a more readily available method to identify situations where an insurer used a third party to pay commission obligations. The general interrogatory has been written in such a way as to not require disclosure if the amounts are settled in full within 90 days, to hopefully scope out situations where an insurer uses a third party for typical accounts payable processing. Mr. Bruggeman said input from industry is welcome if any clarification edits would be helpful in drafting the general interrogatory. This item is a concurrent exposure with the Statutory Accounting Principles (E) Working Group.

Hearing no objection from the Working Group, the proposal was exposed with a 6-week public comment period ending April 27.

e. Agenda Item 2021-05BWG

Mr. Bruggeman stated that this proposal is related to Statutory Accounting Principles (E) Working Group agenda item 2021-03, which was derived from the ongoing SSAP No. 43R—Loan-Backed and Structured Securities project. This proposal is primarily to data capture existing PDF disclosures required in SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, specifically when a reporting entity has entered into a securitization, asset-backed financing or other similar transfer where a significant economic interest in the transferred asset is retained by the reporting entity. This item is a concurrent exposure with the Statutory Accounting Principles (E) Working Group.

Hearing no objection from the Working Group, the proposal was exposed with a 6-week public comment period ending April 27.

4. Received a Memorandum from the Valuation of Securities (E) Task Force

Mr. Garn stated that a memorandum was received from the Valuation of Securities (E) Task Force (Attachment Two-I) dated Feb. 3, 2021, referencing the proposed amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to update the financial modeling instructions for residential mortgage-backed security/commercial mortgage-backed security (RMBS/CMBs) securities and to direct Investment Analysis Office (IAO) staff to produce NAIC designations and NAIC designations categories for non-legacy securities. This adds two new administrative symbols: 1) “FSR,” which identifies a non-legacy security RMBS that is subject to the financial modeling methodology and assignment of an NAIC designation and designation category by the Structured Securities Group (SSG); and 2) “FSC,” which indicates that the specific Committee on Uniform Security Identification Procedures (CUSIP) identifies a non-legacy security CMBs that is subject to the financial modeling methodology and assignment of an NAIC designation and designation category by the SSG. These codes will be added to the designation/modifier/administrative code list on the Blanks (E) Working Group website.

5. Adopted the Editorial Listing

Ms. Gosselin made a motion, seconded by Mr. Drutz, to adopt the editorial listing (Attachment Two-J). The motion passed unanimously.

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6. Discussed Other Matters

Joe Zolecki (Blue Cross and Blue Shield Association—BCBSA) stated that interested parties would be willing to work with a small group of state insurance regulators, NAIC staff and other interested parties as an ad hoc group to study and identify any current gaps, particularly in health filing information, to figure out what carriers can provide that would be meaningful and not redundant with all of the other filings that are already being made. He stated that the Risk-Focused Surveillance (E) Working Group has a charge to consider regulatory redundancies raised by interested parties and recommendations provided to other committees. He questioned whether the issues should be addressed by the Blanks (E) Working Group or by the Risk-Focused Surveillance (E) Working Group, which has a charge of reviewing regulatory redundancy issues.

Mr. Garn stated that this is a big project and that the Blanks (E) Working Group takes each issue one piece at a time, working to make improvements as well as trying to remove elements that are no longer needed while adding more relevant data elements. He stated that if there is something specific within the blanks reporting that interested parties would like to point out, the Blanks (E) Working Group can address that. He stated that a more comprehensive project would involve a number of other groups; for example, the investment issues would involve the Valuation of Securities (E) Task Force, and any statutory reporting issues would involve the Statutory Accounting Principles (E) Working Group.

Having no further business, the Blanks (E) Working Group adjourned.
The Blanks (E) Working Group of the Accounting Practices and Procedures (E) Task Force met Dec. 16, 2020. The following Working Group members participated: Jake Garn, Chair (UT); Kim Hudson, Vice Chair (CA); William Arfanis (CT); N. Kevin Brown (DC); Adrienne Lupo (DE); Carolyn Morgan (FL); Daniel Mathis (IA); Roy Eft (IN); Dan Schaefer (MI); Debbie Doggett (MO); Lindsay Crawford and Justin Schrader (NE); Patricia Gosselin (NH); John Sirovetz (NJ); Dale Bruggeman and Tracy Snow (OH); Diane Carter (OK); Melissa Greiner (PA); Trey Hancock (TN); Jamie Walker (TX); Steve Drutz (WA); Randy Milquet (WI); and Jamie Taylor (WV).

1. **Adopted its Aug. 27 Minutes**

The Working Group met Aug. 27 and adopted five proposals. Among these was: 1) a proposal to add a column to the health blank Schedule T for the breakout reporting of the Children’s Health Insurance Program (CHIP) business; 2) two proposals sponsored by the Statutory Accounting Principles (E) Working Group—one addressing changes made to Statement of Statutory Accounting Principles (SSAP) No. 86—Derivatives for the present value of financing premiums, and another changing the disclosures in the Notes to Financial Statement and Schedule D, Part 6 to reflect changes adopted for SSAP No. 68—Business Combinations and Goodwill and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities; and 3) a proposal adding a new line to Schedule E, Part 2 for reporting qualified cash pools. The Working Group also adopted its editorial listing.

Mr. Eft made a motion, seconded by Mr. Hudson, to adopt the Working Group’s Aug. 27 minutes (see NAIC Proceedings – Fall 2020, Accounting Practices and Procedures (E) Task Force, Attachment Two). The motion passed unanimously.

2. **Discussed a Proposal Previously Deferred**

   a. **Modify the Instructions and Illustration for Note 10L to Reflect the Disclosure Changes for Statement of Statutory Accounting Principles (SSAP) No. 97—Investments in Subsidiary, Controlled and Affiliated Entities Being Considered for Adoption by the Statutory Accounting Principles (E) Working Group (2020-02BWG)**

Mr. Bruggeman stated that this proposal was originally intended to modify the instructions and illustration for Note 10L – Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties to reflect SSAP No. 97 disclosure changes being discussed by the Statutory Accounting Principles (E) Working Group, agenda item Ref #2019-41. Since the discussions are ongoing, he requested to withdraw the proposal with the possibility of submitting a new proposal at a future date. Mr. Garn stated that no action was required by the Blanks (E) Working Group as the sponsor withdrew the proposal.

3. **Adopted Proposals Previously Exposed**

   a. **Remove the Disclosure for the Federal Affordable Care Act (ACA) Section 9010 Assessment from Note 22 – Events Subsequent (SAPWG Ref #2020-05) (2020-28BWG) Effective 12/31/2021**

Mr. Bruggeman stated that this blanks agenda item is related to the Statutory Accounting Principles (E) Working Group agenda item Ref #2020-05: Repeal of the Affordable Care Act Section 9010 Assessment adopted by the Working Group in July for SSAP No. 106—Affordable Care Act Section 9010 Assessment. The proposal removes the disclosure for the assessment from Note 22 – Events Subsequent reflecting the federal Affordable Care Act (ACA) Section 9010 assessment repeal effective Jan. 1, 2021.

Mr. Bruggeman stated that interested parties suggested adding some clarifying language to indicate that quarterly reporting would not be required for this item during 2021. NAIC staff did not agree that the clarifying language was needed as Note 22 is not a required quarterly disclosure and the existing instructions at the beginning of the Notes to Financial Statement should be sufficient. A related ACA guidance document is also being presented during this meeting to assist companies in reporting the note in the 2020 annual statement addressing the fact that there is no fee due in 2021. Mr. Bruggeman stated that there were no modifications made to the proposal.
Mr. Bruggeman made a motion, seconded by Ms. Gosselin, to adopt the proposal (Attachment Two-A1). The motion passed unanimously.

b. Remove the Line Category and Reference to the NAIC Bond Fund List (Bond List) From the Investment Schedule Instructions and Blank (SAPWG 2020-01) (2020-29BWG) Effective 12/31/2021

Mr. Bruggeman stated that this blank proposal is related to the Statutory Accounting Principles (E) Working Group agenda item Ref #2020-01: Update/Remove References to SVO Listings adopted in March, which eliminated references to the NAIC Bond Fund List (Bond List) in SSAP No. 26R—Bonds. It added reference to the “NAIC Fixed Income-Like SEC Registered Funds List” in SSAP No. 30R—Unaffiliated Common Stock. This proposal removes the line category and reference to the bond list from the applicable investment schedule instructions and blanks. There were no comments from interested parties.

Mr. Bruggeman made a motion, seconded by Mr. Drutz, to adopt the proposal (Attachment Two-A2). The motion passed unanimously.

c. Move the Interrogatory Question Regarding Communication of Internal Control Related Matters Noted in Audit From the Annual Supplemental Exhibits and Schedules Interrogatories to the Quarterly Supplemental Exhibits and Schedules Interrogatories to be Answered for the Second Quarter. For Title, a New Page in the Quarterly Statement will be Added for the Supplemental Exhibits and Schedules Interrogatories (2020-30BWG) Effective 12/31/2021

Mr. Hudson stated that this proposal moves the interrogatory question regarding Communication of Internal Control Related Matters Noted in Audit from the annual Supplemental Exhibits and Schedules Interrogatories to the quarterly Supplemental Exhibits and Schedules Interrogatories to be answered for the second quarter. For the Title blank, a new page in the quarterly statement will be added for the Supplemental Exhibits and Schedules Interrogatories.

Mr. Hudson stated that interested parties suggested modifying the quarterly statement interrogatory question to be consistent with the Life Principles-Based Reserve Statement of Exemption quarterly statement interrogatory question. NAIC staff modified the language to indicate that the response for the first and third quarters should be “N/A” and that a “NO” response resulting with a bar code is only appropriate in the second quarter. A similar change will also be made in the NAIC filing directive.

Mr. Hudson made a motion, seconded by Mr. Sirovetz, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Hudson made a motion, seconded by Mr. Sirovetz, to adopt the modified proposal (Attachment Two-A3). The motion passed unanimously.


Paul Peterson (National Organization of Life and Health Guaranty Association—NOLHGA) stated that this proposal replaces the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation and the Adjustments to the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibits that have been in place since the 1990s. It was used to determine the assessable premium basis that is used by the guaranty fund association in its assessment process. There are more lines and instructions, but they should not create an undue burden to the insurance companies as the information reflects the data they have had in the past. Mr. Peterson stated that this new information will make it easier for his team to assess the guaranty fund information.

Mr. Hudson made a motion, seconded by Mr. Drutz, to adopt the proposal (Attachment Two-A4). The motion passed unanimously.
4. **Exposed New Items**

a. **Add a New Health Care Receivables Supplement to the Life/Fraternal Annual Statement that Adds Exhibit 3 and Exhibit 3A from the Health Annual Statement to the Life/Fraternal Annual Filings. Add a Guidance Document Reference to Exhibit 3A of the Health Annual Statement (2020-32BWG)**

Mr. Garn stated that this proposal adds an Exhibit 3 and Exhibit 3A Health Care Receivables Supplement to the life/fraternal annual statement and adds a reference to the guidance document posted as part of the health annual statement health care receivables (HCR) reporting. The purpose is to allow for more consistency of reporting between the life and health blanks with regards to health care receivables and to provide state insurance regulators with detailed health care receivables information from life companies.

Hearing no objection, the Working Group exposed the proposal for a 60-day public comment period ending Feb. 16, 2021.

b. **Modify Annual Statement Lines (ASLs) Used on Underwriting and Investment (U& I) Exhibits, State Page and Insurance Expense Exhibit (IEE). Change Health ASL Categories Used in Property to be Consistent with Other Statement Types. Update ASL References Used in Crosschecks. Update Definitions Used in the Appendix for the Health ASLs (2020-33BWG)**

Mr. Schrader stated that this proposal affects the property/casualty (P/C) blank. It modifies the annual statement lines (ASLs) used in the Underwriting and Investment (U&I) Exhibits, the State Page and the Insurance Expense Exhibit (IEE). It changes the health ASL categories used in the P/C blank to be consistent with other statement types. The purpose is to gain consistency in the granularity of reporting of annual statement lines of business.

Hearing no objection, the Working Group exposed the proposal for a 60-day public comment period ending Feb. 16, 2021.

c. **Add Definitions for the Occupational Accident, Fiduciary Liability, Premises and Operations (OL&T and M&C), Professional Errors and Omissions Liability, Kidnap & Ransom Liability and Tuition Reimbursement Plans Products to the Appropriate Line of Business in the Appendix (2020-34BWG)**

Mr. Garn stated that this proposal includes a change to the P/C blank only. It adds additional definitions for the Occupational Accident, Fiduciary Liability, Premises and Operations (OL&T and M&C), Professional Errors and Omissions Liability, Kidnap & Ransom Liability and Tuition Reimbursement Plans Products to the Appropriate Line of Business in the appendix of the annual statement instructions. The purpose is to provide more clarity of reporting and more consistency in the lines of business between the Property Uniform Product Matrix and the annual statement.

Hearing no objection, the Working Group exposed the proposal for a 60-day public comment period ending Feb. 16, 2021.

d. **Expand the Number of Characters Used From Seven to Ten in the Investment Line Categories for Schedules D, DA, DL and E Excluding Schedule D, Part 6 (Sections 1 and 2) and Schedule E (Part 1 and 3). Add Line Categories for Unaffiliated Certificates of Deposit and Exchange-Traded Funds. Split the Line Categories for Mutual Funds, Investment Unit Trusts and Closed-End Funds into Lines Indicating if the Fund has Been Assigned a Designation by the Securities Valuation Office. Make Changes to Summary Investment Schedule, Summary by Country and Schedule D, Part 1A (Sections 1 and 2) to Reflect the Additional Line Categories (2020-35BWG)**

Mr. Hudson stated that this proposal expands the number of characters used in the investment line categories from seven to ten. The purpose of the change is to accommodate more investment categories and to allow for room in the numbering scheme for Schedule D, Schedule DA, Schedule DL and Schedule E to add additional lines in the future without major disruption of line numbering. It also adds new lines to address crosscheck issues and reporting questions that have been received in the past.

Hearing no objection, the Working Group exposed the proposal for a 60-day public comment period ending Feb. 16, 2021.
Hearing no objection, the Working Group exposed the proposal for a 60-day public comment period ending Feb. 16, 2021.

f. Add a New Schedule Y, Part 3 to Capture All Entities with Ownership Greater Than 10%, the Ultimate Controlling Parties of Those Owners and Other Entities That the Ultimate Controlling Party Controls (SAPWG Ref #2020-34) (2020-37BWG)

Mr. Bruggeman stated that this proposal is in response to the Statutory Accounting Principles (E) Working Group agenda item Ref #2020-34: Related Parties, Disclaimer of Affiliation and Variable Interest Entities associated with SSAP No. 25—Affiliates and Other Related Parties, which was exposed on Nov. 12. In collaboration with interested parties, the Working Group agenda item and this proposal adds a new annual Schedule Y, Part 3 exhibit. This new exhibit would require companies to identify those with an ownership percentage greater than 10%, identify if any owners have a disclaimer of control or affiliation, and identify the controlling parties. He stated that this is not intended to duplicate information reported in Schedule Y, Part 1. The related Statutory Accounting Principles (E) Working Group discussion addressed where the company already has control, being a party owning more than 10% who are not in the chain normally reported on Schedule Y, Part 1. The intent is to identify those insurance companies so that across multiple entities, especially on unrelated entities, those parties would be able to be known if they happened to own more than one insurance company more than 10%.

Hearing no objection, the Working Group exposed the proposal for a 60-day public comment period ending Feb. 16, 2021.

g. Make Changes to the Accident and Health Policy Experience Exhibit by Adding New Columns, Remove Lines Distinguishing With and Without Contract Reserves, Add New Product Lines, Eliminate Summary Tables, Change the Date That the Exhibit is Due and Having it Reported by State (2020-38BWG)

Mr. Garn stated that this proposal makes changes to the Accident and Health Policy Experience Exhibit, which is a uniform schedule. Some of the changes include removing lines for reporting “With Contract Reserves” and “Without Contract Reserves” in the individual business categories. It adds additional columns to the exhibit including: Direct Premiums Written, Assumed Premiums Earned, Ceded Premiums Earned, Net Premiums Earned, Assumed Incurred Claims Amount, Ceded Incurred Claims Amount, and Net Incurred Claims Amount. He stated that the proposal adds a line for “vision” coverage in the group and individual sections. Since the reinsurance amounts are being included in the main exhibit, the summary tables are being eliminated. The proposal requests that the exhibit be reported by state with a change in the filing due date to March 1. The purpose of the proposal is to provide state insurance regulators additional health data and greater consistency across the blanks. The intent of the March 1 filing date is to allow for comparison with the risk-based capital (RBC) filings, which have a March 1 filing due date.

Tip Tipton (Thrivent Financial) stated that interested parties are concerned with the significant change and potential redundancy among other schedules throughout the statement, as well as moving the date up one month in an already tight time frame. He stated that this may be an opportunity for interested parties, state insurance regulators and NAIC staff to collaborate on how industry can provide information that would benefit state insurance regulators but at the same time mitigate potential redundancies.

Ray Nelson (TriPlus Services) representing America’s Health Insurance Plans (AHIP) stated that member companies have reviewed the proposal and are concerned with the volume of data being requested, the potential redundancies with data provided in other areas and exhibits, and the acceleration of the filing deadline. He stated that this is a significant hardship for companies given the effort involved in compiling the data and the resource constraints due to the statement, actuarial opinion and filing
work due March 1. He stated that interested parties request the opportunity to work with state insurance regulators and NAIC staff to review the health data and provide data that is critical for the state analysts and examiners, and identify the data needed March 1 and the data that can wait until April 1. Mr. Nelson stated that interested parties would like to develop a more feasible and permanent proposal that will provide state insurance regulators with necessary health data and reduce the regulatory redundancy in the spirit of the Risk-Focused Surveillance (E) Working Group charges.

Mr. Garn stated that this proposal is only being considered for exposure at this time and that there will be additional opportunity for comments during the exposure period. He stated that consideration has been made to remove some possible redundancy from the state page; however, it is difficult to process a comprehensive proposal all at once because of the timeliness of the needed data.

Mary Caswell (NAIC) stated that NAIC staff have received requests over time from state insurance regulators and from members of the Health Risk-Based Capital (E) Working Group to obtain more consistent health data across all statement types. The Health Risk-Based Capital (E) Working Group has an ad hoc group looking at potential changes to the health test with the intent of having some companies that currently file on the life blank to move to the health blank if they pass the revised health test. This proposal is an attempt to gain more comprehensive health data on the health blank. The ad hoc group was looking at making changes to various exhibits and schedules within the life and health blank to obtain more uniform data. Ms. Caswell stated that this proposal was an attempt to limit the disruptions to the blank for companies, vendors, NAIC staff and state insurance regulators to review. NAIC staff suggested revising this uniform exhibit to accommodate the data being requested by the Health Risk-Based Capital (E) Working Group, as well as data being requested by various state financial analysts and examination regulators and NAIC staff. She stated that this proposal has been reviewed by the Health Actuarial (B) Task Force. It was sent to the Life Actuarial (A) Task Force for review, working to meet state insurance regulator needs without removing needed data.

Ms. Caswell stated that discussions on the health test became somewhat problematic when considering situations where a company might have a separate account that is not accounted for on the health blank; potential treatment for companies that hold an asset valuation reserve; and issues related to companies that write long-term care (LTC) coverage that state insurance regulators prefer to continue to be reported on the life blank. The reporting date issue, whether a March 1 filing or an April 1 filing, can be considered and decided upon by the state insurance regulators. The March 1 date is suggested in the proposal to coincide with the RBC filing in case that group would want to devise direct pulls from the exhibit. The exhibit is currently an April 1 filing, which could remain if the state insurance regulators so decide. The request for state data came more from the analysis side. With the potential future emphasis on health coverage, state insurance regulators may need to have more state-specific data.

Mike Monahan (American Council of Life Insurers—ACLI) stated that this proposal is not ready for exposure at this time and requested the proposal be deferred.

Joe Zolecki (Blue Cross and Blue Shield Association—BCBSA) stated that he would echo the previous interested party comments and indicated that the biggest issue is the March 1 filing date. He stated that he appreciates the efforts of NAIC staff to address redundancy. He stated that he was involved in that effort on the examination side. It seems appropriate to have a long-term project to consider some of the health filings and potential redundancy. He asked that the initial exposure include the April 1 rather than the March 1 filing date if the Blanks (E) Working Group decides not to defer this proposal. He stated that having the April 1 filing date and not having the data by state would give industry time to consider the changes and work with state insurance regulators and NAIC staff to come up with more permanent filings. He stated that interested parties could support an exposure with an April 1 filing date, not requiring the data by state and working together in 2021 to address some of the redundancy issues.

Mr. Garn stated that there is time for further discussion of the proposal during the exposure period, as well as for it to be deferred if needed prior to being considered for adoption. Exposing the proposal allows for industry and state insurance regulators to provide their comments regarding the suggested changes.

Hearing no objection from Working Group members, the Working Group exposed the proposal for a 60-day public comment period ending Feb. 16, 2021.
5. **Adopted the Editorial Listing**

Mr. Lathrop made a motion, seconded by Ms. Gosselin, to adopt the editorial listing (Attachment Two-A5). The motion passed unanimously.

6. **Approved Posting of Reporting Guidance**

   a. **ACA, Note 22 Guidance**

   Mr. Garn stated that with the repeal of the Section 9010 ACA fee beginning Jan. 1, 2021, the Statutory Accounting Principles (E) Working Group recommended filing guidance for companies in completing the Note 22 disclosures regarding the Section 9010 assessment. This guidance will help companies in consistently filling out the annual statement notes at year-end. Hearing no objection, NAIC staff were directed to post the guidance to the Blanks (E) Working Group web page.

   b. **Health Care Receivables (HCR) Guidance (Health Blank)**

   Mr. Garn stated that the HCR Guidance is intended to assist companies in completing Exhibit 3 and Exhibit 3A within the health blank with regards to health care receivables. The intent is to gain greater accuracy and consistency among the filers of HCR data. Hearing no objection, NAIC staff were directed to post the guidance to the Blanks (E) Working Group web page.

7. **Received a Statutory Accounting Principles (E) Working Group Memorandum**

   Mr. Bruggeman stated that a memorandum was submitted to the Blanks (E) Working Group addressing the Statutory Accounting Principles (E) Working Group agenda item Ref #2019-20 – Rolling Short-Term Investments and how that is handled with some definitions for washed sales for Note 17C. The instructional clarification will be included in the 2020 annual statement instructions revisions. The Statutory Accounting Principles (E) Working Group agenda item Ref #2018-26 regarding SCA Loss Tracking – Accounting Guidance – Revisions state that the reported equity method losses of the subsidiary, controlled or affiliate (SCA) would not go negative (thus would stop at zero). However, to the extent there is a financial guarantee or commitment, the guarantee or commitment would be separately captured under SSAP No 5R—Liabilities, Contingencies and Impairment of Assets. This agenda item also updated footnote 10O by removing the “SCA’s reported value” and replacing it with “the amount of any guarantee under SSAP No. 5R.” He stated that this memorandum intends to inform financial statement filers who complete annual statement note 10O that: 1) note 10O no longer requires “SCA’s reported value”; and 2) as the data capture element cannot be completed for year-end 2020 reporting, any financial guarantees recognized under SSAP No. 5R shall be disclosed in narrative format in annual statement Note 10. As noted, the new data element should be included in narrative format for year-end 2020 annual statement reporting.

   Mr. Bruggeman also stated that as a courtesy notification, the Statutory Accounting Principles (E) Working Group has two additional accounting interpretations (INT 2020-10: Reporting Nonconforming Credit Tenant Loans and INT 2020-11: Extension of Ninety-Day Rule for the Impact of 2020 Hurricanes, California Wildfires and Iowa Windstorms). If adopted during the Dec. 18 Statutory Accounting Principles (E) Working Group meeting, they will be posted on the Blanks (E) Working Group web page for year-end reporting guidance.

8. **Discussed Other Matters**

   Mr. Garn stated that this issue is informational only and that there is no action needed by the Blanks (E) Working Group. On the NAIC Financial Statement Filing web page, there is a notation regarding methods of filing a company’s statutory statement, which states: “Note: If disaster(s) or other contingencies prevent timely online filing, authorization to submit a company's filing other than via the Internet Filing Website should come from the company's domiciliary state. Approval from the company's domiciliary state must be submitted to the NAIC along with the filing submitted via alternative media (CD-ROM only).” He stated that the NAIC no longer maintains a system to accommodate CD-ROM filings. Therefore, NAIC staff will remove the language referencing CD-ROM from the web page and participation packet.

Having no further business, the Blanks (E) Working Group adjourned.

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**NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>Dale Bruggeman</th>
</tr>
</thead>
<tbody>
<tr>
<td>TELEPHONE:</td>
<td></td>
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<tr>
<td>EMAIL ADDRESS:</td>
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<tr>
<td>ON BEHALF OF:</td>
<td></td>
</tr>
<tr>
<td>NAME:</td>
<td>Dale Bruggeman</td>
</tr>
<tr>
<td>TITLE:</td>
<td>Chair SAPWG</td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td>Ohio Department of Insurance</td>
</tr>
<tr>
<td>ADDRESS:</td>
<td>50W. Town St., 3rd Fl., Ste. 300 Columbus, OH 43215</td>
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**FOR NAIC USE ONLY**

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<tr>
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<tr>
<td>New Reporting Requirement</td>
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**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

| No Impact | [ X ] |
| Modifies Required Disclosure | [ ] |

**DISPOSITION**

| [ ] Rejected For Public Comment |
| [ ] Referred To Another NAIC Group |
| [ ] Received For Public Comment |
| [ X ] Adopted Date 12/16/2020 |
| [ ] Rejected Date |
| [ ] Deferred Date |
| [ ] Other (Specify) |

**BLANK(S) TO WHICH PROPOSAL APPLIES**

| [ X ] ANNUAL STATEMENT |
| [ ] QUARTERLY STATEMENT |
| [ X ] INSTRUCTIONS |
| [ X ] CROSSCHECKS |
| [ ] Life, Accident & Health/Fraterna l |
| [ X ] Property/Casualty |
| [ X ] Health |
| [ ] Separate Accounts |
| [ ] Protected Cell |
| [ ] Health (Life Supplement) |
| [ ] Title |
| [ ] Other _______________________ |

Anticipated Effective Date: Annual 2021

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Remove the disclosure for the Affordable Care Act Section 9010 Assessment from Note 22 - Events Subsequent.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to reflect disclosure changes adopted by the Statutory Accounting Principles (E) Working Group superseding SSAP No. 106—Affordable Care Act Section 9010 Assessment (Ref #2020-05). The Affordable Care Act Section 9010 assessment has been repealed effective Jan. 1 2021 and these revisions, will remove the disclosure.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: __________________________ |

Other Comments: __________________________ |

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22. Events Subsequent

Refer to SSAP No. 9—Subsequent Events for accounting guidance.

Instruction:

Subsequent events shall be considered either:

Type I – Recognized Subsequent Events:

Events or transactions that provide additional evidence with respect to conditions that existed at the date of the balance sheet, including the estimates inherent in the process of preparing financial statements.

Type II – Nonrecognized Subsequent Events:

Events or transactions that provide evidence with respect to conditions that did not exist at the date of the balance sheet but arose after that date.

For material Type I subsequent events, the nature and the amount of the adjustment shall be disclosed only if necessary to keep the financial statements from being misleading.

Material Type II subsequent events shall not be recorded in the financial statements, but shall be disclosed in the notes to the financial statements. For such events, an entity shall disclose the nature of the event and an estimate of its financial effect, or a statement that such an estimate cannot be made.

An entity also shall consider supplementing the historical financial statements with pro forma financial data. Occasionally, a nonrecognized subsequent event may be so significant that disclosure can best be made by means of pro forma financial data. Such data shall give effect to the event as if it had occurred on the balance sheet date. In some situations, an entity also shall consider presenting pro forma statements. If the Type II subsequent event is of such a nature that pro forma disclosures are necessary to keep the financial statements from being misleading, disclose supplemental pro forma financial data including the impact on net income, surplus, total assets, and total liabilities giving effect to the event as if it occurred on the date of the balance sheet.

Reporting entities shall disclose the dates through which subsequent events have been evaluated along with the dates the statutory reporting statements were issued, or available to be issued.

For the annual reporting period ending December 31, 2013, and thereafter, a reporting entity subject to the assessment under Section 9010 of the Federal Affordable Care Act shall provide a disclosure of the assessment payable in the upcoming year consistent with the guidance provided under SSAP No. 9—Subsequent Events for a Type II subsequent event. The disclosure shall provide information regarding the nature of the assessment and an estimate of its financial impact, including the impact on its risk-based capital position as if it had occurred on the balance sheet date. In accordance with SSAP No. 9, the reporting entity shall also consider whether there is a need to present pro forma financial statements regarding the impact of the assessment, based on its judgment of the materiality of the assessment.
Additionally, for annual reporting periods ending on or after December 31, 2014, the reporting entity shall disclose the amounts reflected in special surplus in the data year. The disclosure shall provide information regarding the nature of the assessment, the estimated amount of the assessment payable for the upcoming year (current year and the prior year), amount of assessment paid (current and prior year) and written premium (current and prior year) that is the basis for the determination of the Section 9010 fee assessment to be paid in the subsequent year (net assessable premium). The disclosure should also provide the Total Adjusted Capital before and after adjustment (as reported in its estimate of special surplus applicable to the Section 9010 fee) and Authorized Control Level (in dollars) to reflect the fee as of the annual reporting date as if it had been reported on the balance sheet date. The reporting entity shall also provide a statement as to whether an RBC action level would have been triggered had the fee been reported as of the balance sheet date.

Illustration:

Type I – Recognized Subsequent Events:

Subsequent events have been considered through __/__/__ for the statutory statement issued on __/__/__.

On February 1, 20___, a settlement was reached in a major lawsuit against the Company. In conjunction with the lawsuit, the Company estimated and recorded a liability of $_______ on Line ___ of the Liabilities, Surplus and Other Funds page. The actual settlement amount of $_______ was paid to the plaintiff on February 10. The change will be recorded in the First Quarter Statement on Line ___ of the Statement of Income.

Type II – Nonrecognized Subsequent Events:

Subsequent events have been considered through __/__/__ for the statutory statement issued on __/__/__.

The Company faces loss exposure from the January 15, 20___ earthquake in the State of __________. This exposure is primarily in the Company’s property and casualty subsidiaries, but also includes potential losses on its real estate and mortgage loan portfolios. Based on a review of the range of expected loss, the Company does not believe this event will have a material impact on its financial condition.

On January 1, 2021, the Company will be subject to an annual fee under Section 9010 of the federal Affordable Care Act (ACA). This annual fee will be allocated to individual health insurers based on the ratio of the amount of the entity’s net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity’s portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. As of December 31, 2020, the Company has written health insurance subject to the ACA assessment, expects to conduct health insurance business in 2021, and estimates their portion of the annual health insurance industry fee to be payable on September 30, 2021 to be $_____. This amount is reflected in special surplus. This assessment is expected to impact risk based capital (RBC) by _____. Reporting the ACA assessment as of December 31, 2020, would not have triggered an RBC action level.
<table>
<thead>
<tr>
<th></th>
<th>Current Year</th>
<th>Prior Year</th>
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<tbody>
<tr>
<td>A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the federal Affordable Care Act (YES/NO)?</td>
<td></td>
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</tr>
<tr>
<td>B. ACA fee assessment payable for the upcoming year</td>
<td>$ ____________</td>
<td>$ ____________</td>
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<td>C. ACA fee assessment paid</td>
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<tr>
<td>D. Premium written subject to ACA 9010 assessment</td>
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<td>E. Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 30)</td>
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<tr>
<td>F. Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 30 minus 22B above)</td>
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<td>G. Authorized Control Level (Five-Year Historical Line 31)</td>
<td>$ ____________</td>
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<td>H. Would reporting the ACA assessment as of December 31, 2020, have triggered an RBC action level (YES/NO)?</td>
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</tbody>
</table>

Detail Eliminated to Conserve Space
22. Events Subsequent

Refer to SSAP No. 9—Subsequent Events for accounting guidance.

Instruction:

Subsequent events shall be considered either:

Type I – Recognized Subsequent Events:

Events or transactions that provide additional evidence with respect to conditions that existed at the date of the balance sheet, including the estimates inherent in the process of preparing financial statements.

Type II – Nonrecognized Subsequent Events:

Events or transactions that provide evidence with respect to conditions that did not exist at the date of the balance sheet but arose after that date.

For material Type I subsequent events, the nature and the amount of the adjustment shall be disclosed only if necessary to keep the financial statements from being misleading.

Material Type II subsequent events shall not be recorded in the financial statements, but shall be disclosed in the notes to the financial statements. For such events, an entity shall disclose the nature of the event and an estimate of its financial effect, or a statement that such an estimate cannot be made.

An entity also shall consider supplementing the historical financial statements with pro forma financial data. Occasionally, a nonrecognized subsequent event may be so significant that disclosure can best be made by means of pro forma financial data. Such data shall give effect to the event as if it had occurred on the balance sheet date. In some situations, an entity also shall consider presenting pro forma statements. If the Type II subsequent event is of such a nature that pro forma disclosures are necessary to keep the financial statements from being misleading, disclose supplemental pro forma financial data including the impact on net income, surplus, total assets, and total liabilities giving effect to the event as if it occurred on the date of the balance sheet.

Reporting entities shall disclose the dates through which subsequent events have been evaluated along with the dates the statutory reporting statements were issued, or available to be issued.

For the annual reporting period ending December 31, 2013, and thereafter, a reporting entity subject to the assessment under Section 9010 of the Federal Affordable Care Act shall provide a disclosure of the assessment payable in the upcoming year consistent with the guidance provided under SSAP No. 9—Subsequent Events for a Type II subsequent event. The disclosure shall provide information regarding the nature of the assessment and an estimate of its financial impact, including the impact on its risk-based capital position as if it had occurred on the balance sheet date. In accordance with SSAP No. 9, the reporting entity shall also consider whether there is a need to present pro forma financial statements regarding the impact of the assessment, based on its judgment of the materiality of the assessment.
Additionally, for annual reporting periods ending on or after December 31, 2014, the reporting entity shall disclose the amounts reflected in special surplus in the data year. The disclosure shall provide information regarding the nature of the assessment, the estimated amount of the assessment payable for the upcoming year (current year and the prior year), amount of assessment paid (current and prior year) and written premium (current and prior year) that is the basis for the determination of the Section 9010 fee assessment to be paid in the subsequent year (net assessable premium). The disclosure should also provide the Total Adjusted Capital before and after adjustment (as reported in its estimate of special surplus applicable to the Section 9010 fee) and Authorized Control Level (in dollars) to reflect the fee as of the annual reporting date as if it had been reported on the balance sheet date. The reporting entity shall also provide a statement as to whether an RBC action level would have been triggered had the fee been reported as of the balance sheet date.

Illustration:

**Type I – Recognized Subsequent Events:**

Subsequent events have been considered through __/__/__ for the statutory statement issued on __/__/__.

On February 1, 20___, a settlement was reached in a major lawsuit against the Company. In conjunction with the lawsuit, the Company estimated and recorded a liability of $_______ on Line ___ of the Liabilities, Surplus and Other Funds page. The actual settlement amount of $_______ was paid to the plaintiff on February 10. The change will be recorded in the First Quarter Statement on Line ___ of the Statement of Income.

**Type II – Nonrecognized Subsequent Events:**

Subsequent events have been considered through __/__/__ for the statutory statement issued on __/__/__.

The Company faces loss exposure from the January 15, 20___ earthquake in the State of __________. This exposure is primarily in the Company’s property and casualty subsidiaries, but also includes potential losses on its real estate and mortgage loan portfolios. Based on a review of the range of expected loss, the Company does not believe this event will have a material impact on its financial condition.

On January 1, 2021, the Company will be subject to an annual fee under Section 9010 of the federal Affordable Care Act (ACA). This annual fee will be allocated to individual health insurers based on the ratio of the amount of the entity’s net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity’s portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. As of December 31, 2020, the Company has written health insurance subject to the ACA assessment, expects to conduct health insurance business in 2021, and estimates their portion of the annual health insurance industry fee to be payable on September 30, 2021 to be $_____. This amount is reflected in special surplus. This assessment is expected to impact risk-based capital (RBC) by _____. Reporting the ACA assessment as of December 31, 2020, would not have triggered an RBC action level.
### Reporting Entity's ACA Assessment and Capital Information

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Current Year</th>
<th>Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the federal Affordable Care Act (YES/NO)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>ACA fee assessment payable for the upcoming year</td>
<td>$ ___</td>
<td>$ ___</td>
</tr>
<tr>
<td>C</td>
<td>ACA fee assessment paid</td>
<td>$ ___</td>
<td>$ ___</td>
</tr>
<tr>
<td>D</td>
<td>Premium written subject to ACA 9010 assessment</td>
<td>$ ___</td>
<td>$ ___</td>
</tr>
<tr>
<td>E</td>
<td>Total Adjusted Capital before surplus adjustment</td>
<td>$ ___</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Five-Year Historical Line 14)</td>
<td></td>
<td></td>
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<tr>
<td>F</td>
<td>Total Adjusted Capital after surplus adjustment</td>
<td>$ ___</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Five-Year Historical Line 14 minus 22B above)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Authorized Control Level</td>
<td>$ ___</td>
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<tr>
<td></td>
<td>(Five-Year Historical Line 15)</td>
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<tr>
<td>H</td>
<td>Would reporting the ACA assessment as of December 31, 2020, have triggered an RBC action level (YES/NO)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Detail Eliminated to Conserve Space**
ANNUAL STATEMENT INSTRUCTIONS – PROPERTY

NOTES TO FINANCIAL STATEMENTS

Detail Eliminated to Conserve Space

22. Events Subsequent

Refer to SSAP No. 9—Subsequent Events for accounting guidance.

Instruction:

Subsequent events shall be considered either:

Type I – Recognized Subsequent Events:

Events or transactions that provide additional evidence with respect to conditions that existed at the date of the balance sheet, including the estimates inherent in the process of preparing financial statements.

Type II – Nonrecognized Subsequent Events:

Events or transactions that provide evidence with respect to conditions that did not exist at the date of the balance sheet but arose after that date.

For material Type I subsequent events, the nature and the amount of the adjustment shall be disclosed only if necessary to keep the financial statements from being misleading.

Material Type II subsequent events shall not be recorded in the financial statements but shall be disclosed in the notes to the financial statements. For such events, an entity shall disclose the nature of the event and an estimate of its financial effect, or a statement that such an estimate cannot be made.

An entity also shall consider supplementing the historical financial statements with pro forma financial data. Occasionally, a nonrecognized subsequent event may be so significant that disclosure can best be made by means of pro forma financial data. Such data shall give effect to the event as if it had occurred on the balance sheet date. In some situations, an entity also shall consider presenting pro forma statements. If the Type II subsequent event is of such a nature that pro forma disclosures are necessary to keep the financial statements from being misleading, disclose supplemental pro forma financial data including the impact on net income, surplus, total assets, and total liabilities giving effect to the event as if it occurred on the date of the balance sheet.

For the annual reporting period ending December 31, 2013, and thereafter, a reporting entity subject to the assessment under Section 9010 of the Federal Affordable Care Act shall provide a disclosure of the assessment payable in the upcoming year consistent with the guidance provided under SSAP No. 9—Subsequent Events for a Type II subsequent event. The disclosure shall provide information regarding the nature of the assessment and an estimate of its financial impact, including the impact on its risk-based capital position as if it had occurred on the balance sheet date. In accordance with SSAP No. 9, the reporting entity shall also consider whether there is a need to present pro forma financial statements regarding the impact of the assessment, based on its judgment of the materiality of the assessment.
Reporting entities shall disclose the dates through which subsequent events have been evaluated along with the dates the statutory reporting statements were issued, or available to be issued.

Additionally, for annual reporting periods ending on or after December 31, 2014, the reporting entity shall disclose the amounts reflected in special surplus in the data year. The disclosure shall provide information regarding the nature of the assessment, the estimated amount of the assessment payable for the upcoming year (current year and the prior year), amount of assessment paid (current and prior year) and written premium (current and prior year) that is the basis for the determination of the Section 9010 fee assessment to be paid in the subsequent year (net assessable premium). The disclosure should also provide the Total Adjusted Capital before and after adjustment (as reported in its estimate of special surplus applicable to the Section 9010 fee) and Authorized Control Level (in dollars) to reflect the fee as of the annual reporting date as if it had been reported on the balance sheet date. The reporting entity shall also provide a statement as to whether an RBC action level would have been triggered had the fee been reported as of the balance sheet date.

Illustration:

Type I – Recognized Subsequent Events:

Subsequent events have been considered through __/__/__ for the statutory statement issued on __/__/__.

On February 1, 20___, a settlement was reached in a major lawsuit against the Company. In conjunction with the lawsuit, the Company estimated and recorded a liability of $_______ on Line ___ of the Liabilities, Surplus and Other Funds page. The actual settlement amount of $_______ was paid to the plaintiff on February 10. The change will be recorded in the First Quarter Statement on Line ___ of the Statement of Income.

Type II – Nonrecognized Subsequent Events:

Subsequent events have been considered through __/__/__ for the statutory statement issued on __/__/__.

The Company faces loss exposure from the January 15, 20___ earthquake in the State of __________. This exposure is primarily in the Company’s property and casualty subsidiaries, but also includes potential losses on its real estate and mortgage loan portfolios. Based on a review of the range of expected loss, the Company does not believe this event will have a material impact on its financial condition.

On January 1, 2021, the Company will be subject to an annual fee under Section 9010 of the federal Affordable Care Act (ACA). This annual fee will be allocated to individual health insurers based on the ratio of the amount of the entity’s net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity’s portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. As of December 31, 2020, the Company has written health insurance subject to the ACA assessment, expects to conduct health insurance business in 2021, and estimates their portion of the annual health insurance industry fee to be payable on September 30, 2021 to be $_____. This amount is reflected in special surplus. This assessment is expected to impact risk-based capital (RBC) by_____. Reporting the ACA assessment as of December 31, 2020, would not have triggered an RBC action level.
<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Current Year</th>
<th>Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the federal Affordable Care Act (YES/NO)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>ACA fee assessment payable for the upcoming year</td>
<td>$ __________</td>
<td>$ __________</td>
</tr>
<tr>
<td>C</td>
<td>ACA fee assessment paid</td>
<td>$ __________</td>
<td>$ __________</td>
</tr>
<tr>
<td>D</td>
<td>Premium written subject to ACA 9010 assessment</td>
<td>$ __________</td>
<td>$ __________</td>
</tr>
<tr>
<td>E</td>
<td>Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 28)</td>
<td>$ __________</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 28 minus 22B above)</td>
<td>$ __________</td>
<td></td>
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<tr>
<td>G</td>
<td>Authorized Control Level (Five-Year Historical Line 29)</td>
<td>$ __________</td>
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<tr>
<td>H</td>
<td>Would reporting the ACA assessment as of December 31, 2020, have triggered an RBC action level (YES/NO)?</td>
<td></td>
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Detail Eliminated to Conserve Space
### NAIC BLANKS (E) WORKING GROUP

**Blanks Agenda Item Submission Form**

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<tr>
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<tr>
<td><strong>TELEPHONE:</strong></td>
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<tr>
<td><strong>EMAIL ADDRESS:</strong></td>
</tr>
<tr>
<td><strong>ON BEHALF OF:</strong></td>
</tr>
<tr>
<td><strong>NAME:</strong> Dale Bruggeman</td>
</tr>
<tr>
<td><strong>TITLE:</strong> Chair SAPWG</td>
</tr>
<tr>
<td><strong>AFFILIATION:</strong> Ohio Department of Insurance</td>
</tr>
<tr>
<td><strong>ADDRESS:</strong> 50W. Town St., 3rd Fl., Ste. 300 Columbus, OH 43215</td>
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<tr>
<td>Agenda Item # 2020-29BWG</td>
</tr>
<tr>
<td>Year 2021</td>
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<tr>
<td>Changes to Existing Reporting [ X ]</td>
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<td>New Reporting Requirement [ ]</td>
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<tr>
<th><strong>REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</strong></th>
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</thead>
<tbody>
<tr>
<td>No Impact [ X ]</td>
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<tr>
<td>Modifies Required Disclosure [ ]</td>
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<table>
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<tr>
<th><strong>DISPOSITION</strong></th>
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<tbody>
<tr>
<td>[ ] Rejected For Public Comment</td>
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<tr>
<td>[ ] Referred To Another NAIC Group</td>
</tr>
<tr>
<td>[ ] Received For Public Comment</td>
</tr>
<tr>
<td>[ X ] Adopted Date 12/16/2020</td>
</tr>
<tr>
<td>[ ] Rejected Date</td>
</tr>
<tr>
<td>[ ] Deferred Date</td>
</tr>
<tr>
<td>[ ] Other (Specify)</td>
</tr>
</tbody>
</table>

### BLANK(S) TO WHICH PROPOSAL APPLIES

- [ X ] ANNUAL STATEMENT
- [ X ] QUARTERLY STATEMENT
- [ X ] INSTRUCTIONS
- [ X ] CROSSCHECKS
- [ X ] BLANK
- [ X ] Life, Accident & Health/Fraternal
- [ X ] Property/Casualty
- [ X ] Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2021

### IDENTIFICATION OF ITEM(S) TO CHANGE

Remove the line category and reference to the NAIC Bond Fund List (Bond List) from the investment schedule instructions and blank.

### REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to reflect disclosure changes adopted by the Statutory Accounting Principles (E) Working Group superseding SSAP No. 26R—Bonds and SSAP No. 30R—Unaffiliated Common Stock (Ref #2020-01) to eliminate references to the NAIC Bond Fund List (Bond List).

### NAIC STAFF COMMENTS

Comment on Effective Reporting Date: ________________________

Other Comments: ________________________

** This section must be completed on all forms.
ANNUAL & QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY & TITLE

INVESTMENT SCHEDULES GENERAL INSTRUCTIONS
(Appplies to all investment schedules)

Detail Eliminated to Conserve Space

General Classifications Bonds Only:

Refer to SSAP No. 26R—Bonds, SSAP No. 43R—Loan-Backed and Structured Securities and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities for additional guidance.

U.S. Government:

U.S. Government shall be defined as U.S. Government Obligations as defined per the Purposes and Procedures Manual of the NAIC Investment Analysis Office.

Detail Eliminated to Conserve Space

SVO Identified Funds:

This category includes all Bond Mutual Funds included on the “List of Bond Mutual Funds Filed with the SVO (Bond Fund List)” and Exchange Traded Funds included on the “List of Exchange Traded Funds Eligible for Reporting as a Schedule D Bond (the ETF Bond List)” as found on the Securities Valuation Office Web page (https://www.naic.org/svo.htm).

Bank Loans

See SSAP No. 26R—Bonds for guidance.
### ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

#### SUMMARY INVESTMENT SCHEDULE

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Include</th>
<th>Column 1</th>
<th>Ref.</th>
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<tbody>
<tr>
<td>1.08</td>
<td>Parent, Subsidiaries and Affiliates</td>
<td>The value of all affiliated debt securities as defined under SSAP No. 97—<em>Investments in Subsidiary, Controlled and Affiliated Entities.</em></td>
<td>should equal the Schedule D, Part 1, Line 5599999.</td>
<td></td>
</tr>
<tr>
<td>1.09</td>
<td>SVO Identified Funds</td>
<td>The value of all Bond Mutual Funds included on the “NAIC Bond Mutual Fund List” as defined in the <em>Purposes and Procedures Manual of the NAIC Investment Analysis Office</em> and Exchange Traded Funds (ETF) included on the “SVO-Identified Bond ETF List” as published on the Securities Valuation Office Web page (<a href="https://www.naic.org/svo.htm">https://www.naic.org/svo.htm</a>) that the SVO has determined are in scope of SSAP No. 26R—<em>Bonds</em> and can be reported on Schedule D, Part 1 and the SVO assigned a NAIC Designation, NAIC Designation Category and SVO Administrative Symbol published in the NAIC’s AVS+ system per the instructions in the <em>Purposes and Procedures Manual of the NAIC Investment Analysis Office</em> on the Compilation and Publication of the SVO List of Investment Securities.</td>
<td>should equal the Schedule D, Part 1, Line 6099999.</td>
<td></td>
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<tr>
<td>1.10</td>
<td>Unaffiliated Bank Loans</td>
<td>The value of all Unaffiliated Bank Loans that are within the scope of SSAP No. 26R—<em>Bonds.</em></td>
<td>should equal the Schedule D, Part 1, Line 6599999.</td>
<td></td>
</tr>
</tbody>
</table>
**ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE**

**SCHEDULE D – SUMMARY BY COUNTRY**

**LONG-TERM BONDS AND STOCKS OWNED DECEMBER 31 OF CURRENT YEAR**

Enter summarized amounts in the appropriate columns by the specified major classifications, subdividing into United States, Canada, and Other Countries where applicable. For purposes of this schedule, investments in Other Countries are considered Foreign Investments. For the definition of Foreign Investment, and Domestic Investment, see instructions to the Supplemental Investment Risk Interrogatories.

**Column 2 – Fair Value**

For certain bonds, values other than actual market may appear in this column. (See Schedule D, Part 1 instructions for details.)

Exclude: Accrued interest.

**Column 3 – Actual Cost**

Include: Brokerage and other related fees, to the extent they do not exceed the fair market value at the date of acquisition.

Exclude: Accrued interest.

**Lines 8 through 11 – Bonds – Industrial and Miscellaneous, SVO Identified Funds, Unaffiliated Bank Loans and Hybrid Securities (Unaffiliated)**

Include: Bond Mutual Funds – as Identified by the SVO and Exchange Traded Funds – as Identified by the SVO reported in Schedule D, Part 1.

Unaffiliated Bank Loans

**Line 13 – Total Bonds**

Columns 1, 2, 3, and 4, should agree with Columns 11, 9, 7 and 10, respectively, in Schedule D, Part 1.

Column 1 should equal Column 1, Line 1 of the Assets page.

**Lines 14 through 17 – Preferred Stocks – Industrial and Miscellaneous (Unaffiliated)**

Include: Exchange Traded Funds (ETFs) reported in Schedule D, Part 2, Section 1.

---

**Detail Eliminated to Conserve Space**
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRACTERNAL, HEALTH, PROPERTY AND TITLE

SCHEDULE D – PART 1A – SECTION 1

QUALITY AND MATURITY DISTRIBUTION OF ALL BONDS OWNED DECEMBER 31
BY MAJOR TYPE AND NAIC DESIGNATION

The schedule summarizes the aggregate book/adjusted carrying value of all bond holdings, including those in Schedule DA and Schedule E, Part 2 by quality, designation, maturity and bond categories. Include short-term and cash equivalent bonds in the category that most closely resembles their credit risk.

The maturity category for a particular holding is determined by the following criteria:

a. Serial issues and mandatory fixed prepayment obligations valued on an amortizable basis may be distributed based on the par value of each scheduled repayment date and the final installment and adjusted for any discount or premium. Such holdings reported at market may be distributed based on market value by applying market rate to each scheduled repayment.

b. (i) Mortgage-backed/loan-backed and structured securities (these securities are considered loan-backed securities and subject to the guidance in SSAP No. 43R—Loan-Backed and Structured Securities) should be distributed based on the anticipated future prepayment cash flows used to value the security.

(ii) Other bonds with optional prepayment provisions should be distributed based on the expected future prepayments used to value the security.

(iii) Bond Mutual Funds – as Identified by the SVO and Exchange Traded Funds – as Identified by the SVO (as described in the Investment Schedules General Instructions) should be reported in Column 6, “No Maturity Date” in Section 9 “SVO Identified Funds.” Only funds reported in Section 9 would be reported in Column 6.

c. Place all holdings in default as to principal or interest in the “Over 20 years” category in the absence of definitive information as to final settlement. Perpetual bonds should also be included in this category.

d. Consider obligations without maturity date and payable on demand to be due within one year if in good standing. Otherwise, include in the “Over 20 years” category, or earlier if justifiable.

There are 14 sections to this schedule: Sections 1 through 10 for each of the 10 bond categories, Section 11 for total bonds current year, Section 12 for total bonds prior year, Section 13 for total bonds publicly traded and Section 14 for total bonds privately placed. The 10 bond categories combine corresponding subtotals from Schedule D, Part 1; Schedule DA, Part 1; and Schedule E, Part 2 as follows, and for each of those 10 bond categories, the total line for Column 7 of each section should equal the sum of the subtotal lines shown below:

Detail Eliminated to Conserve Space
**ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE**

**SCHEDULE D – PART 1A – SECTION 2**

**MATURITY DISTRIBUTION OF ALL BONDS OWNED DECEMBER 31**

**BY MAJOR TYPE AND SUBTYPE**

The schedule summarizes the aggregate book/adjusted carrying value of all bond holdings, including those in Schedule DA and Schedule E, Part 2 by maturity, major bond categories and the subcategories of issuer obligations, and mortgage-backed/loan-backed and structured securities.

The maturity category for a particular holding is determined by the following criteria:

a. Serial issues and mandatory fixed prepayment obligations valued on an amortizable basis may be distributed based on the par value of each scheduled repayment date and the final installment and adjusted for any discount or premium. Such holdings reported at market may be distributed based on market value by applying market rate to each scheduled repayment.

b. (i) Mortgage-backed/loan-backed and structured securities (these securities are considered loan-backed securities and subject to the guidance in SSAP No. 43R—Loan-Backed and Structured Securities) should be distributed based on the anticipated future prepayment cash flows used to value the security.

(ii) Other bonds with optional prepayment provisions should be distributed based on the expected future prepayments used to value the security.

(iii) Bond Mutual Funds – as Identified by the SVO and Exchange Traded Funds – as Identified by the SVO (as described in the Investment Schedules General Instructions) should be reported in Column 6, “No Maturity Date” in Section 9 “SVO Identified Funds.” Only funds reported in Section 9 would be reported in Column 6.

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---

Section 9:

- Exchange Traded Funds – as Identified by the SVO
- **Bond Mutual Funds – as Identified by the SVO**
### SCHEDULE D – PART 1

#### LONG-TERM BONDS OWNED DECEMBER 31 OF CURRENT YEAR

<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
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<tbody>
<tr>
<td>Bonds:</td>
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<tr>
<td>U.S. Governments</td>
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<tr>
<td>Issuer Obligations</td>
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<tr>
<td>Residential Mortgage-Backed Securities</td>
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</tr>
<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>0399999</td>
</tr>
<tr>
<td>Other Loan-Backed and Structured Securities</td>
<td>0499999</td>
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<tr>
<td>Subtotals – U.S. Governments</td>
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<td>SVO Identified Funds</td>
<td></td>
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<tr>
<td>Exchange Traded Funds – as Identified by the SVO</td>
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</tr>
<tr>
<td>Bond Mutual Funds – as Identified by the SVO</td>
<td>5999999</td>
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<tr>
<td>Subtotals – SVO Identified Funds</td>
<td>6099999</td>
</tr>
<tr>
<td>Unaffiliated Bank Loans</td>
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</tr>
<tr>
<td>Unaffiliated Bank Loans – Issued</td>
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<tr>
<td>Unaffiliated Bank Loans – Acquired</td>
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<tr>
<td>Subtotals – Unaffiliated Bank Loans</td>
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<tr>
<td>Total Bonds</td>
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<td>Subtotals – Issuer Obligations</td>
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<td>Subtotals – Residential Mortgage-Backed Securities</td>
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<td>Subtotals – Commercial Mortgage-Backed Securities</td>
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<td>Subtotals – Affiliated Bank Loans</td>
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<tr>
<td>Subtotals – Unaffiliated Bank Loans</td>
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<tr>
<td>Subtotals – Total Bonds</td>
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</tr>
</tbody>
</table>
Column 2 – Description

Give a description of all bonds owned. As appropriate, the reporting entity is encouraged to include data consistent with that reported in Column 31, Issuer and Column 32, Issue. This does not preclude the company from including additional detail to provide a complete and accurate description. Abbreviations may be used as needed.

For Bond Mutual Funds—as Identified by the SVO and Exchange Traded Funds—as Identified by the SVO, enter the complete name of the fund. As appropriate, the reporting entity is encouraged to include data consistent with that reported.

For Certificate of Deposit Account Registry Service (CDARs) or other similar services that have a maturity of greater than one year, individually list the various banking institutions that are financially responsible for honoring certificates of deposit. As appropriate, the name of the name of the banking institutions should follow from the registry of the Federal Financial Institutions Examination Council (FFIEC) (www.ffiec.gov/nicpubweb/nicweb/SearchForm.aspx).

For CDOs (Collateralized Debt Obligations) or CLOs (Collateralized Loan Obligations), indicate what the CDO/CLO collateral is, such as high-yield bonds, corporate loans, etc. If the collateral is of mixed type, indicate “Mix,” in addition to the largest type of collateral in the mix. If the collateral is derived synthetically, indicate “synthetic.”

Detail Eliminated to Conserve Space

Column 16 – Interest Rate

Show rate of interest as stated on the face of the bond. Where the original stated rate has been renegotiated, show the latest modified rate. For long-term bonds with a variable rate of interest, use the last rate of interest. For short-term bonds with various issues of the same issuer, use the last rate of interest. All information reported in this field must be a numeric value.

For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds) and Principal STRIP Bonds or other zero-coupon bonds, enter numeric zero (0).

Column 17 – Effective Rate of Interest

For issuer obligations, include the effective rate at which the purchase was made. For mortgage-backed/loan-backed and structured securities, report the effective yield used to value the security at the reporting date. The Effective Yield calculation should be modified for other-than-temporary impairments recognized.

For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds), enter Zero (0).

Column 18 – Interest – When Paid

For securities that pay interest annually, provide the first 3 letters of the month in which the interest is paid (e.g., JUN for June). For securities that pay interest semi-annually or quarterly, provide the first letter of each month in which interest is received (e.g., JD for June and December, and MJSD for March, June, September and December). For securities that pay interest on a monthly basis, include “MON” for monthly. Finally, for securities that pay interest at maturity, include “MAT” for maturity.

For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds) and Principal STRIP Bonds or other zero-coupon bonds, enter N/A.
Column 20 – Amount Received During Year
For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds) enter the amount of distributions received in cash or reinvested in additional shares.

Include: The proportionate share of interest directly related to the securities reported in this schedule.

Report amounts net of foreign withholding tax.

Column 21 – Acquired Date
For public placements use trade date, not settlement date. For private placements, use funding date. Each issue of bonds or stocks acquired at public offerings on more than one date may be totaled on one line and the date of last acquisition inserted.

For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds), enter date of last purchase.

Column 22 – Stated Contractual Maturity Date
For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds), leave blank.

For perpetual bonds, enter 01/01/9999.

For mandatory convertible bonds use the conversion date.

Column 34 – Capital Structure Code
Please identify the capital structure of the security using the following codes consistent with the SVO Notching Guidelines in the *Purpose and Procedures Manual of the NAIC Investment Analysis Office*:

Capital structure is sometimes referred to as rank or payment priority and can be found in feeds from the sources listed in the Issue and Issuer column.

As a general rule, a security is senior unsecured debt unless legal terms of the security indicate another position in the capital structure. Securities are senior or subordinated and are secured or unsecured. Municipal bonds, Federal National Mortgage Association securities (FNMA or Fannie Mae) and Federal Home Loan Mortgage Corporation securities (FHLMC or Freddie Mac) generally are senior debt, though there are examples of subordinated debt issued by Fannie and Freddie. 1st Lien is a type of security interest and not capital structure but could be used to determine which capital structure designation the security should be reported under. The capital structure of “Other” should rarely be used.

Capital structure includes securities subject to SSAP No. 26R—Bonds and SSAP No. 43R—Loan-Backed and Structured Securities.

1. Senior Secured Debt

   Senior secured is paid first in the event of a default and also has a priority above other senior debt with respect to pledged assets.
2. Senior Unsecured Debt

Senior unsecured securities have priority ahead of subordinated debt for payment in the event of default.

3. Subordinated Debt

Subordinated is secondary in its rights to receive its principal and interest payments from the borrower to the rights of the holders of senior debt (e.g., for loan-backed and structured securities, this would include mezzanine tranches).

(Subordinated means noting or designating a debt obligation whose holder is placed in precedence below secured and general unsecured creditors e.g., another debtholder could block payments to that holder or prevent that holder of that subordinated debt from taking any action.)

4. Not Applicable

Securities where the capital structure 1 through 3 above do not apply (e.g., Line 5899999 Exchange Traded Funds – as Identified by the SVO and Line 5999999 Bond Mutual Funds – as Identified by the SVO).

NAIC Designation Category Footnote:

Provide the total book/adjusted carrying value amount by NAIC Designation Category that represents the amount reported in Column 11.

The sum of the amounts reported for each NAIC Designation Category in the footnote should equal Line 8399999.
ANNUAL & QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY & TITLE

SCHEDULE D – PART 3

LONG-TERM BONDS AND STOCKS ACQUIRED DURING CURRENT YEAR

This schedule should include a detailed listing of all securities that were purchased/acquired during the current reporting year that are still owned as of the end of the current reporting year (amounts purchased and sold during the current reporting year are reported in detail on Schedule D, Part 5 and only in subtotal in Schedule D, Part 3). This should include all transactions that adjust the cost basis of the securities. Thus, it should not be used for allocations of TBAs to specific pools subsequent to initial recording in Schedule D, Part 3 or other situations such as CUSIP number changes. The following list of items provides examples of the items that should be included:

- Purchases of securities not previously owned;
- Subsequent purchases of investment issues already owned;
- Acquisition of a new stock through a stock dividend (e.g., spin off); and
- Any increases in the investments in SCA companies that adjust the cost basis (e.g., subsequent capital infusions [investments] in SCA companies valued using the equity method).

This schedule should NOT be used for stock splits to show increases in the number of shares; nor should it be used for stock dividends to show increases in the number of shares (unless the stock shares received as dividends are in a stock that is not already owned by the reporting entity – e.g., received in a spin off). Rather, for stock splits and stock dividends of an already owned stock, adjustments for the appropriate columns should be made in Schedule D, Part 2, Section 1 and in Schedule D, Part 2, Section 2.

Bonds, preferred stocks and common stocks are to be grouped separately, showing a subtotal for each category.

Bond Mutual Funds— as Identified by SVO and Exchange Traded Funds – as Identified by SVO, which are described in the Investment Schedules General Instructions, are to be included in SVO Identified Funds.

Bonds are to be grouped as listed below and each category arranged alphabetically (securities included in U.S. States, Territories and Possessions; U.S. Political Subdivisions of States, Territories and Possessions; and U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions should be listed with a state abbreviation in the column provided for electronic data capture).

If a reporting entity has any detail lines reported for any of the following required categories or subcategories, it shall report the subtotal amount of the corresponding category or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

<table>
<thead>
<tr>
<th>Column 2</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Give a description of all bonds and preferred and common stocks. As appropriate, the reporting entity is encouraged to include data consistent with that reported in Column 12, Issuer and Column 13, Issue. This does not preclude the company from including additional detail to provide a complete and accurate description. Abbreviations may be used as needed.</td>
</tr>
</tbody>
</table>

For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds), enter complete name of the fund. As appropriate, the reporting entity is encouraged to include data consistent with that reported for Column 12, Issuer.
For Certificate of Deposit Account Registry Service (CDARs) or other similar services that have a maturity of greater than one year, individually list the various banking institutions that are financially responsible for honoring certificates of deposit. As appropriate, the name of the banking institutions should follow from the registry of the Federal Financial Institutions Examination Council (FFIEC) ([www.ffiec.gov/nicpubweb/nicweb/SearchForm.aspx](http://www.ffiec.gov/nicpubweb/nicweb/SearchForm.aspx)).

For CDOs (Collateralized Debt Obligations) or CLOs (Collateralized Loan Obligations), indicate what the CDO/CLO collateral is, such as high-yield bonds, corporate loans, etc. If the collateral is of mixed type, indicate “Mix,” in addition to the largest type of collateral in the mix. If the collateral is derived synthetically, indicate “synthetic.”

<table>
<thead>
<tr>
<th>Column 3</th>
<th>Foreign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insert the appropriate code in the column based on the list provided in the Investment Schedules General Instructions.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 4</th>
<th>Date Acquired</th>
</tr>
</thead>
<tbody>
<tr>
<td>For public placements use trade date, not settlement date. For private placements, use funding date. Each issue of bonds or stocks acquired at public offerings on more than one date may be totaled on one line and the date of last acquisition inserted.</td>
<td></td>
</tr>
</tbody>
</table>

For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds), enter date of last purchase.

<table>
<thead>
<tr>
<th>Column 8</th>
<th>Par Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>For mortgage-backed/loan-backed and structured securities, enter the par amount of principal purchased on a security on which the reporting entity has a claim. For interest only bonds without a principal amount on which the reporting entity has a claim, use a zero value. Enter the statement date par value for bonds with adjustable principal. An interest only bond with a small par amount of principal would use that amount.</td>
<td></td>
</tr>
</tbody>
</table>

For preferred stock, enter par value per share of stock if any.

For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds), enter 0.

<table>
<thead>
<tr>
<th>Column 9</th>
<th>Paid for Accrued Interest and Dividends</th>
</tr>
</thead>
<tbody>
<tr>
<td>For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds), enter amount of dividends on shares acquired between the dividend declaration date and the ex-dividend date.</td>
<td></td>
</tr>
</tbody>
</table>
LONG-TERM BONDS AND STOCKS SOLD, REDEEMED OR OTHERWISE DISPOSED OF DURING CURRENT YEAR

This schedule should include a detailed listing of all securities that were sold/disposed of during the current reporting year that were owned as of the beginning of the current reporting year (amounts purchased and sold during the current reporting year are reported in detail on Schedule D, Part 5 and only in subtotal in Schedule D, Part 4). This should include all transactions that adjust the cost basis of the securities (except other-than-temporary impairments that are not part of a disposal transaction). Thus, it should not be used for allocations of TBAs to specific pools subsequent to initial recording in Schedule D, Part 3 or other situations such as CUSIP number changes. The following list of items provides examples of the items that should be included:

- Pay downs of securities still owned (including CMO prepayments);
- Subsequent partial sales of investment issues still owned;
- Reallocation of the cost basis of an already owned stock to the cost basis of a new stock received as a dividend (e.g., spin off); and
- Any decreases in the investments in SCA companies that adjust the cost basis, not including other-than-temporary impairments alone (e.g., subsequent return of capital from investments in SCA companies valued using the equity method).

Bonds, preferred stocks and common stocks are to be grouped separately, showing a subtotal for each category.

**Bond Mutual Funds—as Identified by the SVO and Exchange Traded Funds—as Identified by the SVO, which are described in the Investment Schedules General Instructions**, are to be included in SVO Identified Funds.

Bonds are to be grouped as listed below and each category arranged alphabetically (securities included in U.S. States, Territories and Possessions; U.S. Political Subdivisions of States, Territories and Possessions; and U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions should be listed with a state abbreviation in the column provided for electronic data capture).

If a reporting entity has any detail lines reported for any of the following required categories or subcategories, it shall report the subtotal amount of the corresponding category or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

<table>
<thead>
<tr>
<th>Column 2</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detail Eliminated to Conserve Space</td>
<td></td>
</tr>
</tbody>
</table>

Give a description of all bonds and preferred and common stock, including location of all banks, trust and miscellaneous companies. If bonds are serial issues, give amounts maturing each year. As appropriate, the reporting entity is encouraged to include data consistent with that reported in Column 24, Issuer and Column 25, Issue. This does not preclude the company from including additional detail to provide a complete and accurate description. Abbreviations may be used as needed.

For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds), enter complete name of the fund. As appropriate, the reporting entity is encouraged to include data consistent with that reported for Column 24, Issuer.
For Certificate of Deposit Account Registry Service (CDARs) or other similar services that have a maturity of greater than one year, individually list the various banking institutions that are financially responsible for honoring certificates of deposit. As appropriate, the name of the banking institutions should follow from the registry of the Federal Financial Institutions Examination Council (FFIEC) (www.ffiec.gov/nicpubweb/nicweb/SearchForm.aspx).

For CDOs (Collateralized Debt Obligations) or CLOs (Collateralized Loan Obligations), indicate what the CDO/CLO collateral is, such as high-yield bonds, corporate loans, etc. If the collateral is of mixed type, indicate “Mix,” in addition to the largest type of collateral in the mix. If the collateral is derived synthetically, indicate “synthetic.”

Column 3 – Foreign

Insert the appropriate code in the column based on the list provided in the Investment Schedules General Instructions.

Column 4 – Disposal Date

For public placements use trade date, not settlement date. For private placements, use funding date. Each issue of bonds or stocks disposed of at public offerings on more than one date may be totaled on one line and the date of last disposal inserted.

For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds), enter date of last disposal.

Column 5 – Name of Purchaser

If matured or called under redemption option, so state and give price at which called.

Column 7 – Consideration

Include: In the determination of this amount, the broker’s commission and incidental expenses of effecting delivery.

Exclude: Accrued interest and dividends.

For Bond Mutual Funds—as Identified by the SVO and Exchange Traded Funds—as Identified by the SVO, enter price received at sale, usually the number of shares sold times the selling price per share.

Column 8 – Par Value

For mortgage-backed/loan-backed and structured securities, enter the par amount of principal sold on a security on which the reporting entity has a claim. For interest only bonds without a principal amount on which the reporting entity has a claim, use a zero value. Enter the sale date par value for bonds with adjustable principal. An interest only bond with a small par amount of principal would use that amount.

For preferred stock, enter par value per share of stock if any.

For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds), enter 0.

Detail Eliminated to Conserve Space
Column 18 – Realized Gain (Loss) on Disposal

This should be the difference between the Consideration column amount and the Book/Adjusted Carrying Value at Disposal Date, excluding any portion that is attributable to foreign exchange differences.

For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds), enter the difference between the consideration, Column 7 and actual cost Column 9 at date of sale.

Bonds called where consideration received exceeds par:

For securities sold, redeemed or otherwise disposed of, which generate investment income as a result of a prepayment penalty and/or acceleration fee, the amount of realized gain (loss) reported is equal to the Par value of the investment (Column 8) less the BACV at the Disposal Date (Column 16).

Bonds called where consideration received is less than par:

For securities sold, redeemed or otherwise disposed of, the amount of investment income and realized gain reported shall be calculated in accordance with SSAP No. 26R—Bonds.

Column 19 – Total Gain (Loss) On Disposal

Enter the sum of Column 17, foreign exchange gain or (loss), and Column 18, realized gain or (loss).

Column 20 – Bond Interest/Stock Dividends Received During Year

For Mutual Funds (including Bond Mutual Funds— as Identified by the SVO and Exchange Traded Funds— as Identified by the SVO), enter the amount of distributions received in cash or reinvested in additional shares.

Include: The proportionate share of investment income directly related to the securities reported in this schedule.

Report amounts net of foreign withholding tax.

Bonds called where consideration received exceeds par:

For securities sold, redeemed or otherwise disposed of, which generate investment income as a result of a prepayment penalty and/or acceleration fee; the amount of investment income reported is equal to the total consideration received (Column 7) less the Par value of the investment (Column 8).

Bonds called where consideration received is less than par:

For securities sold, redeemed or otherwise disposed of, the amount of investment income and realized gain reported shall be calculated in accordance with SSAP No. 26R—Bonds.

Column 21 – Stated Contractual Maturity Date

For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds), leave blank.

For perpetual bonds, enter 01/01/9999.
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SCHEDULE D – PART 5

LONG-TERM BONDS AND STOCKS ACQUIRED DURING THE YEAR AND FULLY DISPOSED OF DURING CURRENT YEAR

This schedule should include a detailed listing of all securities that were both purchased/acquired and sold/disposed of during the current reporting year (amounts purchased and sold during the current reporting year are also reported in subtotals in Schedule D, Parts 3 and 4).

Reporting entities should track information separately for securities purchased in different lots rather than using some type of averaging for the issue in aggregate. Thus, this schedule should only be used when an entire lot of a security has been purchased and sold during the current reporting year (even when different lots of the same security still exist on the reporting entity’s books).

As with Schedule D, Parts 3 and 4, this schedule should not be used for a transaction unless it affects the cost basis of the securities. Thus, it should not be used for allocations of TBAs to specific pools subsequent to initial recording in Schedule D, Part 3 or other situations such as CUSIP number changes.

Bonds, preferred stocks and common stocks are to be grouped separately, showing subtotals for each category. Bonds should be grouped and arranged alphabetically as described in the instructions for Schedule D, Part 1. (Securities included in U.S. States, Territories and Possessions; U.S. Political Subdivisions of States, Territories and Possessions; and U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions should be listed with a state abbreviation in the column provided for electronic data capture).

Bond Mutual Funds – as Identified by the SVO and Exchange Traded Funds – as Identified by the SVO that are described in the Investment Schedules General Instructions are to be included in SVO Identified Funds.

If a reporting entity has any detail lines reported for any of the following required categories or subcategories, it shall report the subtotal amount of the corresponding category or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line number:

<table>
<thead>
<tr>
<th>Column 2 – Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give a description of all bonds and preferred and common stocks, including location of all banks, trust and miscellaneous companies. As appropriate, the reporting entity is encouraged to include data consistent with that reported in Column 24, Issuer and Column 25, Issue. This does not preclude the company from including additional detail to provide a complete and accurate description. Abbreviations may be used as needed.</td>
</tr>
<tr>
<td>For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds), enter complete name of the fund. As appropriate, the reporting entity is encouraged to include data consistent with that reported for Column 24, Issuer.</td>
</tr>
<tr>
<td>For Certificate of Deposit Account Registry Service (CDARs) or other similar services that have a maturity of greater than one year, individually list the various banking institutions that are financially responsible for honoring certificates of deposit. As appropriate, the name of the name of the banking institutions should follow from the registry of the Federal Financial Institutions Examination Council (FFIEC) (<a href="http://www.ffiec.gov/nicpubweb/nicweb/SearchForm.aspx">www.ffiec.gov/nicpubweb/nicweb/SearchForm.aspx</a>).</td>
</tr>
<tr>
<td>For CDOs (Collateralized Debt Obligations) or CLOs (Collateralized Loan Obligations), indicate what the CDO/CLO collateral is, such as high-yield bonds, corporate loans, etc. If the collateral is of mixed type, indicate “Mix,” in addition to the largest type of collateral in the mix. If the collateral is derived synthetically, indicate “synthetic.”</td>
</tr>
</tbody>
</table>
Column 3 – Foreign

Insert the appropriate code in the column based on the list provided in the Investment Schedules General Instructions.

Column 4 – Date Acquired

For public placements use trade date, not settlement date. For private placements, use funding date. Reporting entities may total on one line each issue of bonds or stocks acquired at public offerings on more than one date and insert the date of last acquisition.

For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds), enter date of last purchase.

Column 5 – Name of Vendor

The items with reference to each issue of bonds and stocks acquired at public offerings may be totaled in one line and the word “various” inserted.

Column 6 – Disposal Date

For public placements use trade date, not settlement date. For private placements, use funding date. Reporting entities may total on one line each issue of bonds or stocks disposed of at public offerings on more than one date and insert the date of last disposal.

For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds), enter date of last disposal.

Detail Eliminated to Conserve Space

Column 10 – Consideration

Include: In the determination of this amount, the broker’s commission and incidental expenses of effecting delivery.

Exclude: Accrued interest and dividends.

For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds), enter price received at sale, usually the number of shares sold times the selling price per share.

Detail Eliminated to Conserve Space
Column 20 – Interest and Dividends Received During Year

For Mutual Funds (including Bond Mutual Funds – as Identified by the SVO and Exchange Traded Funds – as Identified by the SVO), enter the amount of distributions received in cash or reinvested in additional shares.

Include: The proportionate share of investment income directly related to the securities reported in this schedule.

Report amounts net of foreign withholding tax.

Bonds called where consideration received exceeds par:

For securities sold, redeemed or otherwise disposed of, which generate investment income as a result of a prepayment penalty and/or acceleration fee, the amount of investment income reported is equal to the total consideration received (Column 10) less the Par value of the investment (Column 8).

Bonds called where consideration received is less than par:

For securities sold, redeemed or otherwise disposed of, the amount of investment income and realized gain reported shall be calculated in accordance with SSAP No. 26R—Bonds.
## SHORT-TERM INVESTMENTS OWNED DECEMBER 31 OF CURRENT YEAR

<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bonds:</strong></td>
<td></td>
</tr>
<tr>
<td>U.S. Governments</td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
<td>0199999</td>
</tr>
<tr>
<td>Residential Mortgage-Backed Securities</td>
<td>0299999</td>
</tr>
<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>0399999</td>
</tr>
<tr>
<td>Other Loan-Backed and Structured Securities</td>
<td>0499999</td>
</tr>
<tr>
<td>Subtotals – U.S. Governments</td>
<td>0599999</td>
</tr>
<tr>
<td>Parent, Subsidiaries and Affiliates Bonds</td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
<td>4999999</td>
</tr>
<tr>
<td>Residential Mortgage-Backed Securities</td>
<td>5099999</td>
</tr>
<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>5199999</td>
</tr>
<tr>
<td>Other Loan-Backed and Structured Securities</td>
<td>5299999</td>
</tr>
<tr>
<td>Affiliated Bank Loans – Issued</td>
<td>5399999</td>
</tr>
<tr>
<td>Affiliated Bank Loans – Acquired</td>
<td>5499999</td>
</tr>
<tr>
<td>Subtotals – Parent, Subsidiaries and Affiliates Bonds</td>
<td>5599999</td>
</tr>
<tr>
<td>SVO Identified Funds</td>
<td></td>
</tr>
<tr>
<td>Exchange Traded Funds – as Identified by the SVO</td>
<td>5699999</td>
</tr>
<tr>
<td>Bond Mutual Funds – as Identified by the SVO</td>
<td>5799999</td>
</tr>
<tr>
<td>Subtotals – SVO Identified Funds</td>
<td>5899999</td>
</tr>
<tr>
<td>Unaffiliated Bank Loans</td>
<td></td>
</tr>
<tr>
<td>Unaffiliated Bank Loans – Issued</td>
<td>6399999</td>
</tr>
<tr>
<td>Unaffiliated Bank Loans – Acquired</td>
<td>6499999</td>
</tr>
<tr>
<td>Subtotals – Unaffiliated Bank Loans</td>
<td>6599999</td>
</tr>
<tr>
<td>Total Bonds</td>
<td></td>
</tr>
<tr>
<td>Subtotals – Issuer Obligations</td>
<td>7699999</td>
</tr>
<tr>
<td>Subtotals – Residential Mortgage-Backed Securities</td>
<td>7799999</td>
</tr>
<tr>
<td>Subtotals – Commercial Mortgage-Backed Securities</td>
<td>7899999</td>
</tr>
<tr>
<td>Subtotals – Other Loan-Backed and Structured Securities</td>
<td>7999999</td>
</tr>
<tr>
<td>Subtotals – SVO Identified Funds</td>
<td>8099999</td>
</tr>
<tr>
<td>Subtotals – Affiliated Bank Loans</td>
<td>8199999</td>
</tr>
<tr>
<td>Subtotals – Unaffiliated Bank Loans</td>
<td>8299999</td>
</tr>
<tr>
<td>Subtotals – Bonds</td>
<td>8399999</td>
</tr>
</tbody>
</table>
ANNUAL & QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY & TITLE

SCHEDULE DL – PART 1

SECURITIES LENDING COLLATERAL ASSETS
Reinvested Collateral Assets Owned December 31 Current Year
(Securities lending collateral assets reported in aggregate on Line 10 of the asset page and not included on Schedules A, B, BA, D, DB and E.)

This schedule should include a detailed listing of reinvested collateral assets that were owned as of the end of the current reporting year. For Schedule DL, reinvested collateral assets are collateral currently held as part of a securities lending program administered by the reporting entity or its agent (affiliated or unaffiliated) that can be resold or repledged. This is the currently held collateral, meaning original collateral if it is still in the original form received or the new invested asset resulting from the disposal and/or reinvestment of the original collateral. See SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities for accounting guidance.

Include reinvested collateral assets from securities lending programs where the program is administered by the reporting entity’s unaffiliated agent (i.e., collateral is received by the reporting entity’s unaffiliated agent that can be resold or repledged). These securities will be reported in aggregate on the Assets page, Line 10.

For reinvested collateral assets from securities lending programs where the program is administered by the reporting entity’s affiliated agent (i.e., collateral is received by the reporting entity’s affiliated agent that can be resold or repledged), the securities may be reported on Schedule DL, Part 1 if reported in aggregate on the Assets page, Line 10 or reported on Schedule DL, Part 2 if reported in other investment schedules (e.g., Schedules A, B, BA, D, DA and E), but not both.

Reinvested collateral assets reported on Schedule DL, Part 1 are excluded from other investment schedules (e.g., Schedules A, B, BA, D, DA and E).

Bonds, preferred stocks and common stocks are to be grouped separately, showing a subtotal for each category.

Securities borrowing and securities lending transactions shall be shown gross when reported in the Schedule DL. If these transactions are permitted to be reported net in accordance with SSAP No. 64—Offsetting and Netting of Assets and Liabilities, the investment schedule shall continue to provide detail of all transactions (gross), with the net amount from the valid right to offset reflected in the financial statements (pages 2 & 3 of the statutory financial statements). Disclosures for items reported net when a valid right to offset exists, including the gross amount, the amount offset, and the net amount reported in the financial statements are required per SSAP No. 64—Offsetting and Netting of Assets and Liabilities.

Bond Mutual Funds—as Identified by the SVO and Exchange Traded Funds – as Identified by the SVO, which are described in the Investment Schedules General Instructions, are to be included in SVO Identified Funds.

If an insurer has any detail lines reported for any of the following required categories or subcategories, it shall report the subtotal amount of the corresponding category or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

NOTE: See the Investment Schedules General Instructions for the following:

- Category definitions for bonds and stocks.
- Code column list of codes and definitions for securities not under the exclusive control of the reporting entity.
- List of stock exchange names and abbreviations.
<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonds (Schedule D, Part 1 type):</td>
<td></td>
</tr>
<tr>
<td>U.S. Governments</td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
<td>0199999</td>
</tr>
<tr>
<td>Residential Mortgage-Backed Securities</td>
<td>0299999</td>
</tr>
<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>0399999</td>
</tr>
<tr>
<td>Other Loan-Backed and Structured Securities</td>
<td>0499999</td>
</tr>
<tr>
<td>Subtotals – U.S. Governments</td>
<td>0599999</td>
</tr>
<tr>
<td>Parent, Subsidiaries and Affiliates</td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
<td>4999999</td>
</tr>
<tr>
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Detail Eliminated to Conserve Space

Column 2 – Description

Give a complete and accurate description of all bonds and preferred and common stocks as listed in the *Valuations of Securities*.

For Bond Mutual Funds – as Identified by the SVO and Exchange Traded Funds – as Identified by the SVO, enter complete name of the fund.

For Certificate of Deposit Account Registry Service (CDARs) or other similar services that have a maturity of greater than one year, individually list the various banking institutions that are financially responsible for honoring certificates of deposit.
ANNUAL & QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY & TITLE

SCHEDULE DL – PART 2

SECURITIES LENDING COLLATERAL ASSETS
Reinvested Collateral Assets Owned December 31 Current Year
(Securities lending collateral assets included on Schedules A, B, BA, D, DB and E
and not reported in aggregate on Line 10 of the asset page.)

This schedule should include a detailed listing of reinvested collateral assets that were owned as of the end of the current reporting year. For Schedule DL, reinvested collateral assets are collateral currently held as part of a securities lending program administered by the reporting entity or its agent (affiliated or unaffiliated) that can be resold or repledged. This is the currently held collateral, meaning original collateral if it is still in the original form received or the new invested asset resulting from the disposal and/or reinvestment of the original collateral. See SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities for accounting guidance.

Include reinvested collateral assets from securities lending programs where the program is administered by the reporting entity (i.e., collateral is received by the reporting entity that can be resold or repledged).

For reinvested collateral assets from securities lending programs where the program is administered by the reporting entity’s affiliated agent (i.e., collateral is received by the reporting entity’s affiliated agent that can be resold or repledged), the securities may be reported on Schedule DL, Part 2 if reported in other investment schedules (e.g., Schedules A, B, BA, D, DA and E) or reported on Schedule DL, Part 1 if reported in aggregate on the Assets page, Line 10, but not both.

Reinvested collateral assets reported on Schedule DL, Part 2 are included in the other investment schedules (e.g., Schedules A, B, BA, D, DA and E).

Bonds, preferred stocks and common stocks are to be grouped separately, showing a subtotal for each category.

Securities borrowing and securities lending transactions shall be shown gross when reported in the Schedule DL. If these transactions are permitted to be reported net in accordance with SSAP No. 64—Offsetting and Netting of Assets and Liabilities, the investment schedule shall continue to provide detail of all transactions (gross), with the net amount from the valid right to offset reflected in the financial statements (pages 2 & 3 of the statutory financial statements). Disclosures for items reported net when a valid right to offset exists, including the gross amount, the amount offset, and the net amount reported in the financial statements are required per SSAP No. 64—Offsetting and Netting of Assets and Liabilities.

Bond Mutual Funds—as Identified by the SVO and Exchange Traded Funds—as Identified by the SVO that are described in the Investment Schedules General Instructions are to be included in SVO Identified Funds.

If an insurer has any detail lines reported for any of the following required categories or subcategories, it shall report the subtotal amount of the corresponding category or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

NOTE: See the Investment Schedules General Instructions for the following:

- Category definitions for bonds and stocks.
- Code column list of codes and definitions for securities not under the exclusive control of the reporting entity.
- List of stock exchange names and abbreviations.

---

Detail Eliminated to Conserve Space

---
## Bonds (Schedule D, Part 1):

### U.S. Governments
- **Issuer Obligations**: 0199999
- **Residential Mortgage-Backed Securities**: 0299999
- **Commercial Mortgage-Backed Securities**: 0399999
- **Other Loan-Backed and Structured Securities**: 0499999
- **Subtotals – U.S. Governments**: 0599999

### Parent, Subsidiaries and Affiliates
- **Issuer Obligations**: 4999999
- **Residential Mortgage-Backed Securities**: 5099999
- **Commercial Mortgage-Backed Securities**: 5199999
- **Other Loan-Backed and Structured Securities**: 5299999
- **Affiliated Bank Loans – Issued**: 5399999
- **Affiliated Bank Loans – Acquired**: 5499999
- **Subtotals – Parent, Subsidiaries and Affiliates**: 5599999

### SVO Identified Funds
- **Exchange Traded Funds – as Identified by the SVO**: 5799999
- **Bond Mutual Funds – as Identified by the SVO**: 5899999
- **Subtotals – SVO Identified Funds**: 5999999

### Unaffiliated Bank Loans
- **Unaffiliated Bank Loans – Issued**: 6099999
- **Unaffiliated Bank Loans – Acquired**: 6199999
- **Subtotals – Unaffiliated Bank Loans**: 6299999

### Total Bonds
- **Subtotals – Issuer Obligations**: 6399999
- **Subtotals – Residential Mortgage-Backed Securities**: 6499999
- **Subtotals – Commercial Mortgage-Backed Securities**: 6599999
- **Subtotals – Other Loan-Backed and Structured Securities**: 6699999
- **Subtotals – SVO Identified Funds**: 6799999
- **Subtotals – Affiliated Bank Loans**: 6899999
- **Subtotals – Bank Loans**: 6999999
- **Subtotals – Total Bonds**: 7099999

---

**Description**

Give a complete and accurate description of all bonds and preferred and common stocks as listed in the *Valuations of Securities*.

For **Bond Mutual Funds – as Identified by the SVO** and **Exchange Traded Funds – as Identified by the SVO**, enter complete name of the fund.

For Certificate of Deposit Account Registry Service (CDARs) or other similar services that have a maturity of greater than one year, individually list the various banking institutions that are financially responsible for honoring certificates of deposit.
### SCHEDULE E – PART 2 – CASH EQUIVALENTS

#### Category

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<td><strong>Detail Eliminated to Conserve Space</strong></td>
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<tr>
<td>Parent, Subsidiaries and Affiliates Bonds</td>
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<td>Bond Mutual Funds – as Identified by the SVO</td>
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<td><strong>Total Cash Equivalents</strong></td>
<td>8899999</td>
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</tbody>
</table>

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Line 13.02 through 13.11 – Report the amounts and percentages of admitted assets held in the ten largest equity interests including equity funds that qualify individually as one of the largest equity interests and a look-through of investments in the shares of non-diversified mutual funds and ETFs, preferred stocks, publicly traded equity securities, and other equity securities (including Schedule BA equity interests). Equity interests in all funds that are diversified in accordance with the Investment Company Act of 1940 do not need to be individually assessed and aggregated to determine the ten largest equity interests. For funds that are not diversified within the meaning of the Investment Company Act of 1940, insurance reporting entities are required to identify actual equity interests within the fund and aggregate those equity interests to determine their ten largest equity interests.

Determine the ten largest equity interests by first aggregating investments included in this line by issuer. For example, the reporting entity owns preferred stock of the XYZ Company of $600,000, common stock of the XYZ Company of $300,000 and $50,000 of XYZ identified through a look-through of a non-diversified stock closed-end fund reported on Schedule D-2-2. The total is $950,000 ($600,000+$300,000+$50,000). The reporting entity also owns bonds issued by the XYZ Company of $500,000 that are excluded from this calculation because bonds are debt instruments. The reporting entity may also have exposure to equity interests in XYZ through mutual funds that are excluded from this calculation as the funds are diversified within the meaning of the Investment Company Act of 1940. Other equity securities include partnerships and Limited Liability Companies (LLC) and any other investments reported in Schedule BA classified as equity.

The following funds shall also be excluded from aggregation as equity interests: SVO-Identified U.S. Direct Obligations / Full Faith And Credit Exempt List of Money Market Mutual Funds, SVO-Identified Bond ETFs, SVO-Identified Bond Mutual Funds and SVO Identified fund investments with underlying characteristics of fixed-income instruments, which do not contain underlying equities and that are outlined within the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*. 

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## SCHEDULE D – PART 1A – SECTION 2 (Continued)

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

<table>
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<th>Distribution by Type</th>
<th>1 Year or Less</th>
<th>Over 1 Year Through 5 Years</th>
<th>Over 5 Years Through 10 Years</th>
<th>Over 10 Years Through 20 Years</th>
<th>Over 20 Years</th>
<th>No Maturity Date</th>
<th>Total Carrying Value as a % of Line 11.08</th>
<th>Total from Col. 7, Prior Year</th>
<th>% From Col. 8, Prior Year</th>
<th>Total Publicly Traded</th>
<th>Total Privately Placed</th>
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<td>13.04 Other Loan-Backed and Structured Securities</td>
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<td>13.09 Line 13.08 as a % of Col. 7</td>
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</tr>
</tbody>
</table>
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

DATE: 10/14/2020

CONTACT PERSON:

TELEPHONE:

EMAIL ADDRESS:

ON BEHALF OF:

NAME: Kim Hudson
TITLE: 
AFFILIATION: California Department of Insurance
ADDRESS: 300 South Spring St.
Los Angeles, CA 90013

FOR NAIC USE ONLY

Agenda Item # 2020-30BWG MOD
Year 2021

Changes to Existing Reporting [ X ]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [ X ]
Modifies Required Disclosure [ ]

DISPOSITION
[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ X ] Adopted Date 12/16/2020
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT
[ X ] QUARTERLY STATEMENT
[ X ] Life, Accident & Health/Fraternal
[ X ] Property/Casualty
[ X ] Health

[ ] INSTRUCTIONS
[ X ] CROSSCHECKS
[ ] Separate Accounts
[ ] Protected Cell
[ ] Health (Life Supplement)
[ X ] Title
[ ] Other _______________________

Anticipated Effective Date: Annual 2021

IDENTIFICATION OF ITEM(S) TO CHANGE

Move the interrogatory question regarding Communication of Internal Control Related Matters Noted in Audit from the Annual Supplemental Exhibits and Schedules Interrogatories to the Quarterly Supplemental Exhibits and Schedules Interrogatories to be answered for the 2nd Quarter. For Title a new page in the Quarterly statement will be added for the Supplemental Exhibits and Schedules Interrogatories.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

By having the question in the annual some companies appear to be answering “yes” to the question on the annual statement but then don't file it. Placing in the quarterly statement puts the answering of the question in the same quarter as the filing of the document.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: ___________________________________________

Other Comments: ______________________________________________________________

** This section must be completed on all forms.  Revised 7/18/2018
### ANNUAL STATEMENT BLANK – LIFE/FRATERNAL

**SUPPLEMENTAL EXHIBITS AND SCHEDULES**

**INTERROGATORIES**

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

#### MARCH FILING

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?</td>
</tr>
<tr>
<td>2.</td>
<td>Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?</td>
</tr>
<tr>
<td>3.</td>
<td>Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?</td>
</tr>
<tr>
<td>4.</td>
<td>Will an actuarial opinion be filed by March 1?</td>
</tr>
</tbody>
</table>

#### APRIL FILING

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>Will Management’s Discussion and Analysis be filed by April 1?</td>
</tr>
<tr>
<td>6.</td>
<td>Will the Life, Health &amp; Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit be filed with the state of domicile and the NAIC by April 1? (Not applicable to fraternal benefit societies)</td>
</tr>
<tr>
<td>7.</td>
<td>Will the Adjustments to the Life, Health &amp; Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (if required) be filed with the state of domicile and the NAIC by April 1? (Not applicable to fraternal benefit societies)</td>
</tr>
<tr>
<td>8.</td>
<td>Will the Supplemental Investment Risks Interrogatories be filed by April 1?</td>
</tr>
</tbody>
</table>

#### JUNE FILING

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.</td>
<td>Will an audited financial report be filed by June 1?</td>
</tr>
<tr>
<td>10.</td>
<td>Will Accountants Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?</td>
</tr>
</tbody>
</table>

#### AUGUST FILING

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td>Will the regulator only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC by August 1?</td>
</tr>
</tbody>
</table>

The following supplemental reports are required to be filed as part of your annual statement filing if your company is engaged in the type of business covered by the supplement. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

#### MARCH FILING

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>112</td>
<td>Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1? (Not applicable to fraternal benefit societies)</td>
</tr>
<tr>
<td>113</td>
<td>Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?</td>
</tr>
<tr>
<td>114</td>
<td>Will the Trusteed Surplus Statement be filed with the state of domicile and the NAIC by March 1?</td>
</tr>
<tr>
<td>115</td>
<td>Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 to Exhibit 5 be filed with the state of domicile and electronically with the NAIC by March 1?</td>
</tr>
<tr>
<td>116</td>
<td>Will the actuarial opinion on non-guaranteed elements as required in interrogatory #3 to Exhibit 5 be filed with the state of domicile and electronically with the NAIC by March 1?</td>
</tr>
<tr>
<td>117</td>
<td>Will the actuarial opinion on X-Factors be filed with the state of domicile and electronically with the NAIC by March 1?</td>
</tr>
<tr>
<td>118</td>
<td>Will the actuarial opinion on Separate Accounts Funding Guaranteed Minimum Benefit be filed with the state of domicile and electronically with the NAIC by March 1?</td>
</tr>
<tr>
<td>119</td>
<td>Will the actuarial opinion on Synthetic Guaranteed Investment Contracts be filed with the state of domicile and electronically with the NAIC by March 1?</td>
</tr>
<tr>
<td>120</td>
<td>Will the Reasonableness of Assumptions Certification required by Actuarial Guideline XXXV be filed with the state of domicile and electronically with the NAIC by March 1?</td>
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<tr>
<td>2120</td>
<td>Will the Reasonableness and Consistency of Assumptions Certification required by Actuarial Guideline XXXV be filed with the state of domicile and electronically with the NAIC by March 1?</td>
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<tr>
<td>2221</td>
<td>Will the Reasonableness of Assumptions Certification for Implied Guaranteed Rate Method required by Actuarial Guideline XXXVI be filed with the state of domicile and electronically with the NAIC by March 1?</td>
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<tr>
<td>2222</td>
<td>Will the Reasonableness and Consistency of Assumptions Certification required by Actuarial Guideline XXXVI (Updated Average Market Value) be filed with the state of domicile and electronically with the NAIC by March 1?</td>
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<td>Question</td>
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<tr>
<td>2423</td>
<td>Will the Reasonableness and Consistency of Assumptions Certification required by Actuarial Guideline XXXVI (Updated Market Value) be filed with the state of domicile and electronically with the NAIC by March 1?</td>
</tr>
<tr>
<td>2424</td>
<td>Will the C-3 RBC Certifications required under C-3 Phase I be filed with the state of domicile and electronically with the NAIC by March 1?</td>
</tr>
<tr>
<td><strong>SUPPLEMENTAL EXHIBITS AND SCHEDULES</strong></td>
<td><strong>INTERROGATORIES</strong></td>
</tr>
<tr>
<td>2425</td>
<td>Will the C-3 RBC Certifications required under C-3 Phase II be filed with the state of domicile and electronically with the NAIC by March 1?</td>
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<tr>
<td>2426</td>
<td>Will the Actuarial Certifications Related to Annuity Nonforfeiture Ongoing Compliance for Equity Indexed Annuities be filed with the state of domicile and electronically with the NAIC by March 1?</td>
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<tr>
<td>2427</td>
<td>Will the actuarial opinion required by the Modified Guaranteed Annuity Model Regulation be filed with the state of domicile and electronically with the NAIC by March 1?</td>
</tr>
<tr>
<td>2428</td>
<td>Will the Actuarial Certification regarding the use of 2001 Preferred Class Tables required by the Model Regulation Permitting the Recognition of Preferred Mortality Tables for Use in Determining Minimum Reserve Liabilities be filed with the state of domicile and electronically with the NAIC by March 1?</td>
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<td>2429</td>
<td>Will the Workers' Compensation Carve-Out Supplement be filed by March 1? (Not applicable to fraternal benefit societies)</td>
</tr>
<tr>
<td>2430</td>
<td>Will Supplemental Schedule O be filed with the state of domicile and the NAIC by March 1?</td>
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<tr>
<td>2431</td>
<td>Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?</td>
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<tr>
<td>2432</td>
<td>Will an approval from the reporting entity’s state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?</td>
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<td>2433</td>
<td>Will an approval from the reporting entity’s state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?</td>
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<td>2434</td>
<td>Will an approval from the reporting entity’s state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?</td>
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<td>2435</td>
<td>Will the VM-20 Reserves Supplement be filed with the state of domicile and the NAIC by March 1?</td>
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<td><strong>APRIL FILING</strong></td>
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<td>2436</td>
<td>Will the confidential Regulatory Asset Adequacy Issues Summary (RAAIS) required by the Valuation Manual be filed with the state of domicile by April 1?</td>
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<td>2437</td>
<td>Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?</td>
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<tr>
<td>2438</td>
<td>Will the Credit Insurance Experience Exhibit be filed with the state of domicile and the NAIC by April 1? (Not applicable to fraternal benefit societies)</td>
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<td>2439</td>
<td>Will the Accident and Health Policy Experience Exhibit be filed by April 1?</td>
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<td>2440</td>
<td>Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?</td>
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<td>2441</td>
<td>Will the regulator only (non-public) Supplemental Health Care Exhibit’s Allocation Report be filed with the state of domicile and the NAIC by April 1?</td>
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<td>2442</td>
<td>Will the confidential Actuarial Memorandum required by Actuarial Guideline XXXVIII 8D be filed with the state of domicile by April 30?</td>
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<td>2443</td>
<td>Will the Supplemental Term and Universal Life Insurance Reinsurance Exhibit be filed with the state of domicile and the NAIC by April 1?</td>
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<td>2444</td>
<td>Will the Variable Annuities Supplement be filed with the state of domicile and the NAIC by April 1?</td>
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<td>2445</td>
<td>Will the confidential Executive Summary of the PBR Actuarial Report be filed with the state of domicile by April 1?</td>
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<tr>
<td>2446</td>
<td>Will the confidential Life Summary of the PBR Actuarial Report be filed with the state of domicile by April 1?</td>
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<tr>
<td>2447</td>
<td>Will the confidential Variable Annuities Summary of the PBR Actuarial Report be filed with the state of domicile by April 1?</td>
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<tr>
<td><strong>AUGUST FILING</strong></td>
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<tr>
<td>2448</td>
<td>Will Management’s Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?</td>
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ANNUAL STATEMENT BLANK – HEALTH

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

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<tbody>
<tr>
<td>1. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?</td>
<td>....................................................</td>
</tr>
<tr>
<td>2. Will an actuarial opinion be filed by March 1?</td>
<td>....................................................</td>
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<tr>
<td>3. Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?</td>
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<td>4. Will the confidential Risk-based Capital Report be filed with the state of domicile, if required by March 1?</td>
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<td>7. Will the Accident and Health Policy Experience Exhibit be filed by April 1?</td>
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<table>
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<tr>
<td>8. Will an audited financial report be filed by June 1?</td>
<td>....................................................</td>
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<td>9. Will Accountants Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?</td>
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<th>AUGUST FILING</th>
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<tr>
<td>10. Will the regulator-only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC (as a regulator-only non-public document) by August 1?</td>
<td>....................................................</td>
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<td>....................................................</td>
</tr>
<tr>
<td>1411. Will the Supplemental Life data due March 1 be filed with the state of domicile and the NAIC?</td>
<td>....................................................</td>
</tr>
<tr>
<td>1412. Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1?</td>
<td>....................................................</td>
</tr>
<tr>
<td>1413. Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 on Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?</td>
<td>....................................................</td>
</tr>
<tr>
<td>1414. Will the actuarial opinion on non-guaranteed elements as required in Interrogatory 3 to Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?</td>
<td>....................................................</td>
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<tr>
<td>1415. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?</td>
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</tr>
<tr>
<td>1416. Will an approval from the reporting entity’s state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?</td>
<td>....................................................</td>
</tr>
<tr>
<td>1417. Will an approval from the reporting entity’s state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?</td>
<td>....................................................</td>
</tr>
<tr>
<td>1418. Will an approval from the reporting entity’s state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?</td>
<td>....................................................</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>APRIL FILING</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1420. Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?</td>
<td>....................................................</td>
</tr>
<tr>
<td>1421. Will the Supplemental Life data due April 1 be filed with the state of domicile and the NAIC?</td>
<td>....................................................</td>
</tr>
<tr>
<td>1422. Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?</td>
<td>....................................................</td>
</tr>
<tr>
<td>1423. Will the regulator-only (non-public) Supplemental Health Care Exhibit’s Allocation Report be filed with the state of domicile and the NAIC by April 1?</td>
<td>....................................................</td>
</tr>
<tr>
<td>1424. Will the Life, Health &amp; Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit be filed with the state of domicile and the NAIC by April 1?</td>
<td>....................................................</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AUGUST FILING</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1425. Will Management’s Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?</td>
<td>....................................................</td>
</tr>
</tbody>
</table>
ANNUAL STATEMENT BLANK –PROPERTY

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason, enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

MARCH FILING

1. Will an actuarial opinion be filed by March 1? ....................................................
2. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1? ....................................................
3. Will the confidential Risk-based Capital Report be filed with the NAIC by March 1? ....................................................
4. Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1? ....................................................

APRIL FILING

5. Will the Insurance Expense Exhibit be filed with the state of domicile and the NAIC by April 1? ....................................................
6. Will Management’s Discussion and Analysis be filed by April 1? ....................................................
7. Will the Supplemental Investment Risks Interrogatories be filed by April 1? ....................................................

MAY FILING

8. Will this company be included in a combined annual statement that is filed with the NAIC by May 1? ....................................................

JUNE FILING

9. Will an audited financial report be filed by June 1? ....................................................
10. Will Accounts Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1? ....................................................

AUGUST FILING

11. Will the regulator only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC by August 1? ....................................................

The following supplemental reports are required to be filed as part of your statement filing if your company is engaged in the type of business covered by the supplement. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason, enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

MARCH FILING

<table>
<thead>
<tr>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1?</td>
</tr>
<tr>
<td>Will the Financial Guaranty Exhibit be filed by March 1?</td>
</tr>
<tr>
<td>Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?</td>
</tr>
<tr>
<td>Will Supplement A to Schedule T (Medical Professional Liability Supplement) be filed by March 1?</td>
</tr>
<tr>
<td>Will the Trusted Surplus Statement be filed with the state of domicile and the NAIC by March 1?</td>
</tr>
<tr>
<td>Will the Premiums Attributed to Protected Cells Exhibit be filed by March 1?</td>
</tr>
<tr>
<td>Will the Reinsurance Summary Supplemental Filing for General Interrogatory 9 be filed with the state of domicile and the NAIC by March 1?</td>
</tr>
<tr>
<td>Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?</td>
</tr>
<tr>
<td>Will the confidential Actuarial Opinion Summary be filed with the state of domicile, if required, by March 15 (or the date otherwise specified)?</td>
</tr>
<tr>
<td>Will the Reinsurance Attestation Supplement be filed with the state of domicile and the NAIC by March 1?</td>
</tr>
<tr>
<td>Will the Exceptions to the Reinsurance Attestation Supplement be filed with the state of domicile by March 1?</td>
</tr>
<tr>
<td>Will the Bail Bond Supplement be filed with the state of domicile and the NAIC by March 1?</td>
</tr>
<tr>
<td>Will the Director and Officer Insurance Coverage Supplement be filed with the state of domicile and the NAIC by March 1?</td>
</tr>
<tr>
<td>Will an approval from the reporting entity’s state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?</td>
</tr>
<tr>
<td>Will an approval from the reporting entity’s state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?</td>
</tr>
<tr>
<td>Will an approval from the reporting entity’s state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 17?</td>
</tr>
<tr>
<td>Will the Supplemental Schedule for Reinsurance Counterparty Reporting Exception – Asbestos and Pollution contracts be filed with the state of domicile and the NAIC by March 17?</td>
</tr>
</tbody>
</table>

APRIL FILING

<table>
<thead>
<tr>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will the Credit Insurance Experience Exhibit be filed with the state of domicile and the NAIC by April 1?</td>
</tr>
<tr>
<td>Will the Long-term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?</td>
</tr>
<tr>
<td>Will the Accident and Health Policy Experience Exhibit be filed by April 1?</td>
</tr>
<tr>
<td>Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?</td>
</tr>
<tr>
<td>Will the regulator-only (non-public) Supplemental Health Care Exhibit’s Allocation Report be filed with the state of domicile and the NAIC by April 1?</td>
</tr>
<tr>
<td>Will the Cybersecurity and Identity Theft Insurance Coverage Supplement be filed with the state of domicile and the NAIC by April 1?</td>
</tr>
<tr>
<td>Will the Life, Health &amp; Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit be filed with the state of domicile and the NAIC by April 1?</td>
</tr>
<tr>
<td>Will the Adjustments to the Life, Health &amp; Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (if required) be filed with the state of domicile and the NAIC by April 1?</td>
</tr>
<tr>
<td>Will the Private Flood Insurance Supplement be filed with the state of domicile and the NAIC by April 1?</td>
</tr>
</tbody>
</table>

AUGUST FILING

<table>
<thead>
<tr>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will Management’s Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?</td>
</tr>
</tbody>
</table>
### ANNUAL STATEMENT BLANK – TITLE

#### SUPPLEMENTAL EXHIBITS AND SCHEDULES

**INTERROGATORIES**

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of **WAIVED** to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not filed for whatever reason, enter **SEE EXPLANATION** and provide an explanation following the interrogatory questions.

### MARCH FILING

1. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1? .................................................................
2. Will an actuarial opinion be filed by March 1? .................................................................

### APRIL FILING

3. Will Management’s Discussion and Analysis be filed by April 1? .................................................................
4. Will the Supplemental Schedule of Business Written by Agency be filed with the state of domicile by April 1? .................................................................
5. Will the Supplemental Investment Risk Interrogatories be filed by April 1? .................................................................

### JUNE FILING

6. Will an audited financial report be filed by June 1? .................................................................
7. Will Accountants Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1? .................................................................

### AUGUST FILING

8. Will the regulator only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC (as a regulator only non-public document) by August 1? .................................................................

### Response

#### MARCH FILING

---

#### APRIL FILING

---

#### JUNE FILING

---

#### AUGUST FILING

---

The following supplemental reports are required to be filed as part of your statement filing **if your company is engaged in the type of business covered by the supplement. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below.** If the supplement is required of your company but is not filed for whatever reason enter **SEE EXPLANATION** and provide an explanation following the interrogatory questions.

### MARCH FILING

98. Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1? .................................................................
109. Will an approval from the reporting entity’s state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1? .................................................................
1110. Will an approval from the reporting entity’s state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1? .................................................................
1211. Will an approval from the reporting entity’s state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1? .................................................................

### AUGUST FILING

1212. Will Management’s Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1? .................................................................
### QUARTERLY STATEMENT BLANK – LIFE/FRATERNAL

**SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES**

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

<table>
<thead>
<tr>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Will the Truested Surplus Statement be filed with the state of domicile and the NAIC with this statement?</td>
</tr>
<tr>
<td>2. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC with this statement?</td>
</tr>
<tr>
<td>3. Will the Reasonableness of Assumptions Certification required by Actuarial Guideline XXXV be filed with the state of domicile and electronically with the NAIC?</td>
</tr>
<tr>
<td>4. Will the Reasonableness and Consistency of Assumptions Certification required by Actuarial Guideline XXXV be filed with the state of domicile and electronically with the NAIC?</td>
</tr>
<tr>
<td>5. Will the Reasonableness of Assumptions Certification for Implied Guaranteed Rate Method required by Actuarial Guideline XXXVI be filed with the state of domicile and electronically with the NAIC?</td>
</tr>
<tr>
<td>6. Will the Reasonableness and Consistency of Assumptions Certification required by Actuarial Guideline XXXVI (Updated Average Market Value) be filed with the state of domicile and electronically with the NAIC?</td>
</tr>
<tr>
<td>7. Will the Reasonableness and Consistency of Assumptions Certification required by Actuarial Guideline XXXVI (Updated Market Value) be filed with the state of domicile and electronically with the NAIC?</td>
</tr>
<tr>
<td>8. Will the Life PBR Statement of Exemption be filed with the state of domicile by July 1st and electronically with the NAIC with the second quarterly filing per the Valuation Manual (by August 15)? (2nd Quarter Only) The response for 1st and 3rd quarters should be N/A. A NO response resulting with a bar code is only appropriate in the 2nd quarter.</td>
</tr>
<tr>
<td>9. Will the regulator-only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC (as a regulator-only non-public document) by August 17? (2nd Quarter Only) The response for 1st and 3rd quarters should be N/A. A NO response resulting with a bar code is only appropriate in the 2nd quarter.</td>
</tr>
</tbody>
</table>

### QUARTERLY STATEMENT BLANK – HEALTH

**SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES**

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

<table>
<thead>
<tr>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC with this statement?</td>
</tr>
<tr>
<td>2. Will the regulator-only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC (as a regulator-only non-public document) by August 17? (2nd Quarter Only) The response for 1st and 3rd quarters should be N/A. A NO response resulting with a bar code is only appropriate in the 2nd quarter.</td>
</tr>
</tbody>
</table>
QUARTERLY STATEMENT BLANK –PROPERTY

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

Response

1. Will the Trusteed Surplus Statement be filed with the state of domicile and the NAIC with this statement? ............................................
2. Will Supplement A to Schedule T (Medical Professional Liability Supplement) be filed with this statement? ............................................
3. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC with this statement? ............................................
4. Will the Director and Officer Insurance Coverage Supplement be filed with the state of domicile and the NAIC with this statement? ............................................
5. Will the regulator-only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC (as a regulator-only non-public document) by August 1? (2nd Quarter Only) The response for 1st and 3rd quarters should be N/A. A NO response resulting with a bar code is only appropriate in the 2nd quarter. ............................................................

QUARTERLY STATEMENT BLANK –TITLE

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

Response

1. Will the regulator-only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC (as a regulator-only non-public document) by August 1? (2nd Quarter Only) The response for 1st and 3rd quarters should be N/A. A NO response resulting with a bar code is only appropriate in the 2nd quarter. ............................................................

W:\National Meetings\2021\Spring\TF\App\BlanksWG\minutes\Att A3_2020-30BWG_Modified.doc
# NAIC BLANKS (E) WORKING GROUP

## Blanks Agenda Item Submission Form

**DATE:** 10/20/2020

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>Paul Peterson</th>
</tr>
</thead>
<tbody>
<tr>
<td>TELEPHONE:</td>
<td>703.787.4119</td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
<td><a href="mailto:ppeterson@nolhga.com">ppeterson@nolhga.com</a></td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
<td>life, health and annuity guaranty associations</td>
</tr>
<tr>
<td>NAME:</td>
<td>Paul Peterson</td>
</tr>
<tr>
<td>TITLE:</td>
<td>Vice President, Accounting &amp; Finance</td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td>NOLHGA</td>
</tr>
<tr>
<td>ADDRESS:</td>
<td>13873 Park Center Road, Suite 505, Herndon, VA 20171</td>
</tr>
</tbody>
</table>

**FOR NAIC USE ONLY**

<table>
<thead>
<tr>
<th>Agenda Item #</th>
<th>2020-31BWG</th>
<th>Year</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes to Existing Reporting</td>
<td>[X]</td>
<td>New Reporting Requirement</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

| No Impact | [X] |
| Modifies Required Disclosure | [ ] |

**DISPOSITION**

| Rejected For Public Comment | [ ] |
| Referred To Another NAIC Group | [ ] |
| Received For Public Comment | [ ] |
| Adopted Date | 12/16/2020 |
| Rejected Date | [ ] |
| Deferred Date | [ ] |
| Other (Specify) | [ ] |

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- [X] ANNUAL STATEMENT
- [X] INSTRUCTIONS
  - [X] Life and Accident & Health
  - [ ] Separate Accounts
  - [ ] Other Specify
- [X] CROSSCHECKS
  - [X] Property/Casualty
  - [ ] Fraternal
  - [ ] Title
- [X] BLANK
  - [X] Life and Accident & Health
  - [ ] Separate Accounts
  - [ ] Other Specify

Anticipated Effective Date: Annual 2021

**IDENTIFICATION OF ITEM(S) TO CHANGE**

To replace the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation and the Adjustments to the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibits with modernized exhibits as indicated below in order to promote consistent reporting of assessable premiums among industry members and to reflect changes in guaranty association laws adopted over the past two decades.

**DRAFTING NOTE LIFE, HEALTH and PROPERTY ANNUAL STATEMENT BLANK AND INSTRUCTIONS**

For the Life, Health and Annuity Guaranty Association Assessable Premium Exhibits Parts 1 and 2 - edit the blank and instructions as shown below. The Exhibits are to continue to be filed as stand-alone supplemental exhibits in each of the life, health and property blanks due April 1.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

To have all member companies of the life, health and annuity guaranty associations consistently file the revised referenced exhibits for purposes of collecting guaranty association assessable premium data.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: ________________

Other Comments: ________________

**This section must be completed on all forms.**
ANNUAL STATEMENT INSTRUCTIONS – LIFE, HEALTH AND PROPERTY

LIFE, HEALTH AND ANNUITY GUARANTY ASSOCIATION ASSESSABLE PREMIUM MODEL ACT

ASSESSMENT BASE RECONCILIATION EXHIBIT – PARTS 1 & 2

To be filed on or before April 1.

This 2-part exhibit must be completed for any state, District of Columbia, and Puerto Rico in which the company is licensed and should be submitted to the applicable jurisdictions that jurisdiction. In addition, an exhibit should be prepared for any state, District of Columbia, and Puerto Rico in which the company received any direct premiums or deposits. DO NOT SUBMIT exhibits for American Samoa, Guam, U.S. Virgin Islands, Canada, Northern Mariana Islands and other alien jurisdictions. A copy of the exhibit for each jurisdiction and a grand total page for both Parts 1 and 2 must be completed and the exhibits that are submitted should be sent to the state of domicile and the NAIC Support and Services Office.

Only companies that are members of the life, health and annuity guaranty associations should complete this exhibit. If a company is unsure if it is a member of a life, health and annuity guaranty association, it should contact the state life, health and annuity guaranty associations in its state of domicile or state(s) where it is licensed to write life, health and annuity business.

For the purpose of these instructions, references to Schedule T apply to the Life and Health blank and references to the Exhibit of Premiums and Losses apply to the Property blank.

Part 1 develops gross premiums that will be subject to further reduction in Part 2 for guaranty association coverage and/or assessment limitations. Attention should be focused on the deduction items in Part 2, in particular those associated with certain accident and health products and the various types of annuity classifications for allocated and unallocated products.

The columnar headings correspond to the annual statement, Schedule T (Life or Health blanks) or Exhibit of Premiums and Losses (Property blank) as follows:

<table>
<thead>
<tr>
<th>Health Blank Schedule T Column Reference</th>
<th>Col. 4 - Life &amp; Annuity Premiums &amp; Other Considerations (In-part)</th>
<th>Col. 6 - Accident and Health Insurance Premiums</th>
<th>Col. 9 - Deposit-Type Contract Funds</th>
<th>Col. 6 - Life &amp; Annuity Premiums &amp; Other Considerations (In-part)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Exhibit</td>
<td>Col. 1 - Life Insurance Premiums</td>
<td>Col. 2 - Life Contracts—Life Insurance Premiums</td>
<td>Col. 4 - Accident and Health Insurance Premiums</td>
<td>Col. 5 - Other Considerations</td>
</tr>
<tr>
<td>Life Blank Schedule T Column Reference</td>
<td></td>
<td>Col. 3 - Accident and Health Insurance Premiums</td>
<td>Col. 7 - Deposit-Type Contract Funds</td>
<td>Col. 4 - Other Considerations</td>
</tr>
<tr>
<td></td>
<td>Col. 2 - Accident and Health Insurance Premiums</td>
<td>Col. 3 - Deposit-Type Contract Funds</td>
<td>Col. 4 - Other Considerations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Col. 4 - Deposit-Type Contract Funds</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Property Blank Exhibit of Premiums and Losses (Statutory Page 14) Column Reference</th>
<th>Col. 1 - Direct Premiums Written Lines 13-15.8 (Various Accident and Health Insurance Premiums)</th>
</tr>
</thead>
</table>

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In the event that this detailed information is not available in the reporting entity’s accounting records, recognized allocation to estimation processes for state allocations may be utilized if consistently applied.

Adjustments to the exhibit may be required by states that have not adopted the Life and Health Insurance Guaranty Association Model Act (#520).
PURPOSE OF THE LIFE, HEALTH AND ANNUITY GUARANTY ASSOCIATION
ASSESSABLE PREMIUM MODEL ACT ASSESSMENT BASE RECONCILIATION EXHIBIT – PARTS 1 and 2

It is desirable to display on one page the various types of annuity considerations, deposit-type contract funds and other considerations received directly by the reporting entity, separated by state, as is currently reported in the applicable Schedule T or Exhibit of Premiums and Losses; but, however, it is not possible to use such data for state guaranty association assessments without further modification. This is because of: (a) the limits placed on certain considerations for assessment purposes; (b) the variations by states in designation of “funds” for assessments; and (c) other factors that are interpreted differently by the individual states.

As a result, the NAIC and NOLHGA have developed a two-part specific exhibit, the Life, Health & Annuity Guaranty Association Assessable Premium Model Act Assessment Base Reconciliation Exhibit (the “Assessable Premium Base Reconciliation Exhibit”) that utilizes the state figures in Schedule T or Exhibit of Premiums and Losses as the starting point for development of the guaranty association assessment base and then allows for certain adjustments in order to arrive at the applicable assessable premium base for each state as defined in the NAIC Life and Health Insurance Guaranty Association Model Act (#520). States should not use Schedule T or Exhibit of Premiums and Losses as the basis for guaranty association assessments, but instead use the Assessable Premium Base Reconciliation Exhibit for the applicable assessment premium starting point.

Introduction

These instructions are intended to assist companies in completing the Assessable Premium Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit-Parts 1 and 2 (the “AEP Pt. 1” (Base Reconciliation Exhibit) and “AEP Pt. 2”, respectively). Both AEP Parts 1 Adjustments to the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (Adjustments Exhibit). The and 2 must be prepared Base Reconciliation Exhibit starts with the same carepremiums, deposit-type contract funds and accuracy that would be usedother considerations as reported in preparing the applicable Schedule T or Exhibit of Premiums and Losses and then makes necessary adjustments (both positive and negative) to establish the Annual Statement, sincepremium assessment base as defined by the information is being provided to the Guaranty Associations. COMPANIES MUST READ THESE INSTRUCTIONS CAREFULLY AND REFER TO THE RELEVANT GUARANTY ASSOCIATION ACTS, WHERE APPROPRIATE.

AEP Pt. 1 and AEP Pt. 2current Model #520. The Base Reconciliation Exhibit must be completed, along with a grand total page for both, for each state (as well as the District of Columbia and Puerto Rico) in which the company is licensed or does business.

The AEP Pt. 1 and Pt. 2 each have four columns. Column 1 is for all individual and group life insurance premiums. Column 2 is for all allocated annuity amounts (whether called premiums, deposit-type contract funds, or other considerations) and includes both allocated and unallocated annuity governmental retirement plans established under Sections 401, 403(b) or 457 of the U.S. Internal Revenue Code (“IRC”). Column 3 is for all individual and group accident and health premiums. Column 4 is for all unallocated annuity amounts (whether called premiums, deposit-type contract funds, or other considerations) other than amounts received in connection with governmental retirement plans established under IRC Sections 401, 403(b) or 457 (which should be in Column 2).

Should you have questions about how to fill out the Assessable Premium Base Reconciliation Exhibit, and the answers are not provided in the instructions below, you may wish to consult the Model #520, particular State Guaranty Association Acts, the Annual Statement Instructions manual, your company attorney, particular State Insurance Departments, or particular State Guaranty Association Administrators.
# Assessable Premium

The Base Reconciliation Exhibit - Part has four columns: Column 1 is for all individual and group life insurance premiums; Column 2 is for all individual and group allocated annuity amounts (whether called The APE Pt. 1 starts with premiums, deposit-type contract funds and/or other considerations as reported in the applicable Schedule T or the Exhibit of Premiums and Losses); Column 3 is for all individual and then makes necessary adjustments (both positive for group accident and negative) to establish the initial assessable premium base before certain annuity adjustments as defined by each states’ guaranty association act.

### Base Reconciliation Exhibit

### Premiums, Considerations and Deposits from Schedule T or the Exhibit of Premiums and Losses

**Line 1** - THESE AMOUNTS MUST EXACTLY MATCH THE AMOUNTS REPORTED BY YOUR COMPANY ON SCHEDULE T OR THE EXHIBIT OF PREMIUMS AND LOSSES FOR ALL LINES OF BUSINESS.

**Line 1** - THESE AMOUNTS MUST EXACTLY MATCH THE AMOUNTS REPORTED BY YOUR COMPANY ON SCHEDULE T OR THE EXHIBIT OF PREMIUMS AND LOSSES FOR ALL LINES OF BUSINESS.

### Modifications to Premiums, Considerations and Deposits

Lines 2 through 10 are required to adjust amounts reported on your company’s Annual Statement Schedule T or Exhibit of Premiums and Losses and are critical in transforming premium data prepared for Annual Statement purposes into data suitable for Guaranty Association assessment purposes.

**Line 2.1 - 2.99** - Enter any life, annuity or health premiums, deposit-type contract funds and other considerations, received by your company that were not reported by state on Schedule T or the Exhibit of Premiums and Losses and, therefore, not included in Line 1 above. The total of Line 2 should equal Line 2.1 + Line 2.2. Such amounts should be reported in the appropriate column based on whether such amounts relate to life insurance, annuity, accident and health, or annuity and deposit-type business. Include all amounts received for insurance contracts. Guaranteed investment contract receipts, universal life insurance deposits and any other amounts received by the company for covered contracts that were not reported on the company’s Schedule T or the Exhibit of Premiums and Losses (sometimes referred to as FASB 97 deposit reporting) must be reported on Line 2. Annuity amounts entered on Lines 1 and 2 must include, but are not limited to, amounts received for immediate or deferred annuity contracts, structured settlement agreements, lottery contracts, group annuity contracts, guaranteed interest or investment contracts, deposit administration contracts and allocated or unallocated funding obligations. In addition, allocate by state and include on Line 2 amounts reported on the applicable Schedule T or Company Contributions for Employee Benefit Plans (Line 60 (Health blank) or 90 (Life blank) of Schedule T), Dividends Applied to Purchase Paid-Up Additions and Annuities, Dividends Applied to Shorten Endowment or Premium-Paying Period, Premium or Annuity Considerations Waived Under Disability or Other Contract Provisions, and Aggregate Other Amounts Not Allocable by State.

**Line 2.1** - Enter fees and charges for investment management, administration and contract guarantees from the Separate Account associated with variable contracts, reduced by any contractholder dividends representing a return of such fees and charges. Specifically, in the case of variable annuity products, those portions of fees and charges paid to the general account with respect to living and death benefit guarantees, M&E charges and annual contract charges should be included on Line 2.1. In the case of variable life products with guaranteed death benefits, the portion of fees/charges paid to the general account that should be included on Line 2.1 would include the cost of insurance in addition to M&E charges and annual contract charges. Because the fees and charges are reportable by state, a reporting entity may use either a seriatim, i.e., specific contract identification by state, or an allocation method. An appropriate allocation method would be to calculate a ratio of fee income to total variable premium for the product line and multiply the ratio by the state specific variable premium.
Enter any other life, annuity or health premiums, deposit-type contract funds and other considerations, received by your company that were not reported by state on Schedule T or the Exhibit of Premiums and Losses, Guaranteed investment contract receipts, universal life insurance deposits and any other amounts received by the company for covered contracts that were not reported on the company’s Schedule T, Exhibit of Premiums and Losses, or Line 1 above, must be reported on Line 2.6.

Allocate by state and include on Lines 2.2 through 2.6 amounts reported on the corresponding line on Schedule T as Company Contributions for Employee Benefit Plans, Dividends Applied to Purchase Paid-Up Additions and Annuities, Dividends Applied to Shorten Endowment or Premium-Paying Period, Premium or Annuity Considerations Waived under Disability or Other Contract Provisions and Aggregate Other Amounts Not Allocable by State (such as FEGLI/SEGLI).

If by state information is not readily available, reasonable allocation methods may be used to estimate state amounts. “Data not available by state” or similar comments are not valid reasons to exclude these items.

The primary purpose of Lines 3.1 to 3.99 is to add back amounts that, as a result of statutory accounting practices, were deducted from the amounts reported on Line 1 or 2. For the most part, these deductions represent current year benefit payouts, transfers, surrenders or withdrawals.

Enter any amounts deducted prior to determining amounts included in Lines 1 and 2. Companies reporting net amounts on Lines 1 and 2 must complete Lines 3.1 through 3.99 in order to provide gross premiums and deposits. Amounts reported on these lines should include transfers to separate accounts, GIC rollovers to other companies, surrenders, excess interest, and any other amounts deducted from or not included in the company’s gross premium figures. Amounts that were reported as “Unallocated Annuity Deposit-Type Contract Funds and Other Unallocated Fund Deposits Considerations” (Column 4) in the year of receipt and transferred in the current year to “Allocated Annuity and Other Allocated Fund Deposits Considerations” (Column 2), as individuals are “annuitized,” are to be included on Line 3.3 of Column 4 if these amounts were deducted from the amounts reported on Lines 1 or 2. As illustrated below, adding these amounts back to Column 4 may be necessary as amounts over $5 million may have been deducted in prior years—Lines 1 or 2.

As an example, most pension plan unallocated annuities provide for the purchase of an annuity payout benefit (“annuitization”) for an individual. In the year of the receipt of the consideration for the unallocated annuity, that consideration, subject to limitations, is to be included in the total assessable premium assessment base reported in Line 1044, Column 4. In the year of annuitization, the amounts transferred to fund the annuity payout benefits are to be included in the total assessable premium assessment base reported in Line 1044, Column 2. There should be no corresponding reduction to the total assessment base reported in Line 1044, Column 4 for the amount transferred to fund the annuitization to the extent that such amounts would not have been included in an assessment base. When an annuity payout benefit is, pursuant to that contract, purchased for an individual from monies previously deposited with the Company, it is assumed that there is no new contract, rather, it is an internal rollover of funds, i.e., and no new funds have been received by the Company has received no new funds.

In order to correctly report amounts subject to assessment in Columns 2 and 4, companies should maintain transaction level detail for each deposit type contract. On a cumulative basis, the assessable premium can never be less than $0 on any given contract. For example, the following will illustrate the correct reporting of deposit-type contracts that partially or fully annuitize in a model act state (i.e., assessable premium up to $5 million per unallocated annuity contract). The amount reported on APE Pt. 2 Line 17.32.4 is a balancing amount such that the assessable premium for any unallocated contract never exceeds $5 million nor is less than $0 over the life of the contract. The same approach applies to any state that covers unallocated annuities, irrespective of the limits. In this example, there is a $50 million unallocated contract in Year 1 and the company reports $5 million in Column 4 ($50 million on Line 1 or 2, APE Pt. 1, and a reduction of $45 million via Line 17.3 of APE Pt. 2). If the contract is completely annuitized in year 2, the company must report $50 million in Column 2 as allocated premium (APE Pt. Line 1 or 2) and $50 million on Line 3.3, Part 1 (as an add—back) in the unallocated premium column. The Company should report a deduction of $5 million on APE Pt. 2 Line 17.32.4 in Column 4 in the second year. Since it has reported the full $50 million received in Column 2 by the end of the
second year. On a cumulative basis, $0 is reported in Column 4. The Company has not subjected to assessment more premium than it has received.

(Millions of Dollars)

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<th>Example - Contract</th>
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Four additional examples will further illustrate the correct reporting of deposit type contracts that partially or fully annuitize in a model act state. In these examples, it can be seen that at any point in time, the Company has never included more in the assessable premium base (Columns 2 and 4 combined) than what was received by the Company over that period of time. Also, the Company never included more than $5 million of assessable premium in Column 4 at any point in time.

(Millions of Dollars)

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</tr>
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</table>
For Contract #1, the Company received $25 million of deposits and included $20 million in the assessable premium base ($15 million as annuity considerations and $5 million as deposit funds) over the five-year period.

(Millions of Dollars)

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<th>Contract #2</th>
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<td>35 X X</td>
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For Contract #2, the Company received $35 million of deposits and included $35 million in the assessable premium base ($35 million as annuity considerations and $0 as deposit funds) over the five-year period.

(Millions of Dollars)

<table>
<thead>
<tr>
<th>Contract #3</th>
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<th>Year Yr 2</th>
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<th>Year Yr 4</th>
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<tr>
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<td>0 X X</td>
<td>0 X X</td>
<td>0 X X</td>
<td>20 X X</td>
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<td>15 X X</td>
</tr>
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<td>X 2 3 X</td>
<td>X 1 4 X</td>
<td>X 8 8 X</td>
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</tr>
<tr>
<td>Amt. Rep.</td>
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</table>

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For Contract #3, the Company received $20 million of deposits and included $20 million in the assessable premium base ($15 million as annuity considerations and $5 million as deposit funds) over the five-year period.

For Contract #4, the Company received $25 million of deposits and included $220 million in the assessable premium base ($15 million as annuity considerations and $5 million as deposit funds) over the five-year period. Contract #4 is different from Contract #1 in that after Year 2, only $3 million has been included in Column 4 since $7 million of the $10 million of deposits received has annuitized. For Year 3, $2 million is included in Column 4, bringing the cumulative total to $5 million, since a total of $15 million has been received, but only $7 million has annuitized.

You must provide a clear explanation of any amounts listed within Lines 3.501, 3.502, 3.503, etc. Line 3.99 (Total) should represent the difference between gross and net premiums for each column.

**Lines 4.1 through 4.4 are intended to transfer allocated and unallocated premiums between Columns 2 and 4 due to reporting differences with how a company may reflect such premiums in Schedule T (and thus Line 1 since Schedule T is the starting point of the APE Pt. 1). If transfers are properly completed:**

**Table: APE Pt. 2 Line 17.37.4**

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**Table: Cumulative All Years Line 2244**

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- Column 2 should contain BOTH allocated and unallocated annuities associated with governmental retirement plans qualified under IRC Sections 401, 403(b) and 457 and all other allocated annuities.

- Column 4 should contain unallocated annuities associated with benefit plans protected by the Federal Pension Benefit Guaranty Corporation (“PBGC”), government lotteries, book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets owned by the trustee (commonly referred to as “synthetic GICS”), and all other unallocated annuities including those that fund employee, union or association of natural persons benefit plans (other than those associated with governmental retirement plans qualified under IRC Sections 401, 403(b) or 457, which should be included in Column 2 as mentioned above).

Line 4.1 Transfer amounts received to fund annuity contracts qualified under Internal Revenue Code Section 403(b) (sometimes referred to as tax-sheltered annuities) from the Annuity Considerations column (Column 2) to the Deposit-Type Contract Funds and Other Considerations column (Column 4). This transfer line should be completed by companies that report 403(b) annuity amounts in the Life Contracts—Annuity Considerations column 3 (Life blank) or Life & Annuity Premiums & Other Considerations Column 6 in part (Health blank) of Schedule T. All 403(b) amounts in that column should be transferred to Column 4 of the Base Reconciliation Exhibit, whether the 403(b) contract was issued to a governmental or non-governmental policyholder. The amount entered as a negative in the Annuity Considerations column must exactly match the amount entered as a positive in the Deposit-Type Contract Funds and Other Considerations column.

NOTE: In 1995, the NAIC adopted changes to Section 6.A(1)(b) and 6.A(1)(c) of the Model #520 which effectively reclassified contracts issued under a governmental retirement plan established under Section 401, 403(b) or 457 of the U.S. Internal Revenue Code from the unallocated annuity to the allocated annuity account (Non-governmental 401 and 403(b) contracts funded by an unallocated annuity contract remain in the unallocated annuity account.) Although now inconsistent with the adopted change, Base Exhibit, Line 4.1 must continue to be completed in accordance with the instructions in the preceding paragraph since no state has yet adopted this change. Changes to future annual statement instructions, forms or formula charts will be considered at such future date if and when adopted by individual state(s).

Line 4.2 Transfer any allocated annuity amounts included in the Deposit-Type Contract Funds and Other Considerations column (Column 4) to the Annuity Considerations column (Column 2), except for amounts received to fund annuity contracts qualified under Internal Revenue Code Section 403(b) contracts. This includes all allocated annuity contracts, regardless of whether the annuity is in deferred or payout status, whether the annuity is group or individual, and whether the annuity is qualified or non-qualified for tax purposes.

According to Model #520, an “unallocated annuity contract means any annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer or reporting entity under the such contract or certificate.” An annuity is considered allocated unless it is unallocated. Examples of unallocated annuity contracts might be guaranteed investment contracts, deposit administration contracts, and unallocated funding agreements where no contract or agreement issued by the reporting entity, nor any certificate issued by the reporting entity guarantees individual benefits to specifically identified individuals.

Annuity contracts issued by the reporting entity that are held or owned in an individual retirement account under IRC Section 408(a) (whether the account is a custodial account or a trust), or which qualify as individual retirement annuities under IRC Section 408(b), should be considered allocated.

Group annuities may be allocated or unallocated. (The term “unallocated” is not synonymous with the term “group”.) A group contract or certificate that guarantees annuity benefits to an individual (this is not the guarantee typically found in a guaranteed investment contract or deposit administration contract which allows the pension trustee or administrator to purchase an annuity for a plan participant at a guaranteed purchase rate) should be considered allocated. In addition to contracts under which periodic payments are being made to individuals, group annuity contracts should be considered allocated if the reporting entity is obligated under the contract upon the request of an individual (or his or her beneficiary) to make either partial or full cash withdrawal payments, which may be subject to plan or statutory restrictions, to the individual (or his or her beneficiary).
The reporting entity will be considered to be obligated upon the request of an individual to make either partial or full cash withdrawal payments if withdrawals or death benefit payments are made from that participant’s account maintained (by the reporting entity or its designee) under the terms of the group annuity contract and regardless of whether such requests are submitted to the reporting entity directly by the individual (or his or her beneficiary) or indirectly through the plan trustee, administrator, sponsor or contract holder at the direction of the individual. As discussed in Line 4.1, the NAIC adopted a change to Model #520 that reclassifies governmental retirement plans established under Section 401, 403(b) and 457 of the Internal Revenue Code to the allocated annuity account. However, until adopted by a state legislature, 403(b) annuities should remain in the Deposit-Type Contract Funds and Other Considerations column (Column 4) to be consistent with existing statutes that require that these contracts be included with unallocated annuities for assessment purposes where applicable. Note that the amount entered as a negative in the Deposit-Type Contract Funds and Other Considerations column must exactly match the amount entered as a positive in the Annuity Considerations column.

Line 4.1 – 3 Transfer any unallocated annuity amounts received to fund ALLOCATED contracts qualified under IRC Sections 401, 403(b) or 457 from included in the Unallocated Annuity Column (Column 4) to the Allocated Annuity Column Considerations column (Column 2). Companies that report these amounts in the Annuity Considerations Column 5 or 7 (Life blank) or Life & Annuity Premiums & Deposit-Type Contract Funds and Other Considerations Column 6 in part (Health blank) of Schedule T, should complete this transfer line.

All amounts received for allocated contracts qualified under IRC Sections 401, 403(b) or 457 should be transferred to Column 2 of the APE Pt. 1, whether the contracts were issued to a governmental or non-governmental policyholder column (Column 4). The amount entered as a negative in the Unallocated Annuity Column (Column 4) Considerations column must exactly match the amount entered as a positive in the Allocated Annuity Column (Column 2).

Line 4.2 – Transfer all amounts received to fund UNALLOCATED contracts for governmental plans (or its trustee) qualified under IRC Sections 401, 403(b) or 457 from the Unallocated Annuity Column (Column 4) to the Allocated Annuity Column (Column 2). Companies that report these amounts in the Annuity Considerations Column 5 or 7 (Life blank) or Life & Annuity Premiums & Deposit-Type Contract Funds and Other Considerations Column 6 in part (Health blank) of Schedule T, should complete this transfer line. The amount entered as a negative in the Unallocated Annuity Column (Column 4) must exactly match the amount entered as a positive in the Allocated Annuity Column (Column 2).

Line 4.3 – Transfer any allocated annuity amounts included in the Unallocated Annuity Column (Column 4) to the Allocated Annuity Column (Column 2), except for amounts received to fund allocated annuity contracts qualified under IRC Sections 401, 403(b) or 457, which are to be transferred on Line 4.1. This includes all allocated annuity contracts, regardless of whether the annuity is in deferred or payout status, whether the annuity is group or individual, whether the annuity is qualified or non-qualified for tax purposes and whether the annuity is held or owned in an individual retirement account under IRC Section 408(a) or an individual retirement annuity under IRC Section 408(b). The amount entered as a negative in the Unallocated Annuity Column (Column 4) must exactly match the amount entered as a positive in the Allocated Annuity Column (Column 2).

Line 4.4 – Transfer any unallocated annuity amounts included in the Allocated Annuity Column (Column 4) other than amounts that fund unallocated contracts owned by a governmental retirement plan (or its trustee) established under IRC Sections 401, 403(b) or 457. The amount entered as a negative in the Allocated Annuity Column must exactly match the amount entered as a positive in the Unallocated Annuity Column.

Line 4.99 – Total for Lines 4.1 through 4.4 Columns 2 and 4. The sum of Columns 2 and 4 on Lines 4.1 through 4.99 should equal zero (0) for each state.

Development of Amounts Included in Lines 1 through Through 5 That Should Be Deducted in Determining the Gross Premium Base

On both APE Part 1 and 2, companies Lines 6 through 9.99 are deductions from assessable premium based on the Life and Health Insurance Guaranty Association Model Act (#520) provisions. Companies must be careful not to deduct the same...
premium or deposits on more than one line. For example, amounts deducted on Line 6.1 as non-guaranteed separate account deposits should not be deducted a second time on APE Pt. 2. Lines 7.3 if those separate account deposits represent unallocated annuity deposits for a pension plan contract in excess of $5 million. Companies may only deduct amounts on Lines 6 through 9.99 (except for certain dividends allowed amounts on Line 98) to the extent those amounts have been included on Lines 1 through 5 of APE Pt. 1. Lines 6 through 9 are allowable exclusions prior to deductions on APE Pt. 2. the Base Reconciliation Exhibit.

Lines 6.01 – 6.99 Enter amounts received for any portion of a policy or contract not guaranteed by the reporting entity, or under which the investment risk is borne entirely by the policy or contract holder. These amounts are those specified at the time of deposit as intended for deposit in separate accounts. Amounts entered on this line are typically non-guaranteed separate account premiums. DO NOT INCLUDE on these lines amounts transferred to any guaranteed separate accounts.

**Two types of annuity contracts that should NOT be reported on Line 6 are:** (i) modified guaranteed annuities, market-adjusted annuities, or other contracts where the amounts payable on at least one future date do not (or may not) depend solely on the investment performance of assets in the separate accounts; and (ii) guaranteed investment contracts issued to fund pension plans, even if there are no mortality guarantees or only incidental mortality guarantees. Such contracts are not properly includable on Line 6 since the reporting entity retains an investment risk.

Amounts entered on Line 6 should correspond to amounts reported on the Annual Statement of Separate Accounts to the extent amounts are included on Lines 1 through 5 of the APE Pt. 1. Line 6 Base Reconciliation Exhibit. Specify deductions and indicate where such amounts were reported in the Annual Statement. Lines 6.1 – 6.99 should not include transfers to a separate account except to the extent such transfers represent current year premiums included on Lines 1 through 5 of the APE Pt. 1. Do NOT include such amounts in APE Pt. 2 line items. Base Reconciliation Exhibit. Companies must specifically identify deductions on Lines 6.01 through 6.99 and indicate where such amounts are reported in the Annual Statement and where they are reported on Lines 1 through 5 of the Base Reconciliation Exhibit.

Line 7 Enter amounts received during the current year for unallocated annuity contracts associated with the Federal Home Loan Bank Program BUT ONLY IF included in Line 5 above. Do NOT include such amounts in APE Pt. 2. line items.

Line 8 Enter amounts received during the current year only for supplemental contacts (with and without life contingencies) and contracts associated with retained asset programs BUT ONLY IF such amounts are included in APE Pt. 1 Line 5 AND the prior year amounts for the original contracts were reported as assessable premium. For example, if the original premiums were reported as life premiums but deducted as variable separate account business, then the supplemental contract funds would not be an allowable deduction since the original premiums were not reported as assessable premium in the prior years. Do NOT include such amounts in APE Pt. 2. line items.

Line 9 Enter dividends, but only if such amounts were not guaranteed in advance. Examples of items that might be reported on Line 9 include dividends applied to pay renewal premiums, paid in cash or left on deposit. Dividends applied to shorten the endowment or premium paying period or to provide paid-up additions or annuitants may also be included BUT ONLY IF such items are also reported on APE Pt. 1 Line 2.3 or 2.4. Lines 7.1 – 7.4 Enter unallocated amounts that meet the descriptions provided on Lines 7.1, 7.2 and 7.3.

Line 7.1 Allows a deduction for any. Excess interest should not be deducted as dividends.
Assessable Premium Base – Part 1

Line 10 – Assessable premium base before further adjustments.

Footnote 1 – Costs associated with long-term care business are now to be allocated among all accounts (historically they have been treated solely as health business) such that the costs are allocated between life and health companies as defined in the guaranty association statutes or plan of operations for long-term care cost allocation purposes only. In general, the allocation is designed to achieve a 50/50 split, although variances may occur by state. In order to determine if a member company is a life or health company, assessable health premiums for this purpose only are to exclude premiums associated with disability and long-term care business. Report in Footnote 1 (Parts a and b) the assessable premium for standalone business included on APE Pt. 1 Line 10 for these blocks. Include both short term and long-term disability premiums. Do NOT include disability or long-term care premiums that relate to coverage under a rider attached to a life or annuity product. Premiums for these riders should be reported with the original base policy designation (e.g. life or annuity).

Footnote 2 – Please provide for each state in which business is reported the primary contact information that a guaranty association may use to address assessment inquiries (billing, payment etc.).

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Assessable Premium Exhibit – Part 2

The APE Pt. 2 has the same four columns used for APE Pt. 1. Column 1 is for all individual and group life insurance premiums. Column 2 is for all allocated annuity amounts (whether called premiums, deposits, or considerations), including annuities held or owned in an individual retirement account under IRC Section 408(a) (whether the account is a custodial account or a trust), or which qualify as individual retirement annuities under IRC Section 408(b) and both allocated and unallocated annuity governmental retirement plans established under IRC Sections 401, 403(b) or 457. Column 3 is for all individual and group accident and health premiums. Column 4 is for all unallocated annuity amounts (whether called premiums, deposits, or considerations) other than amounts received contract that is not issued to or in connection with governmental retirement benefit plans qualified under IRC Sections 401, 403(b) or 457 (which should be in Column 2). Companies are required to complete each line of the APE Pt. 2 for all states, District of Columbia and Puerto Rico in which they were licensed or had business during the reporting year along with a grand total page. DO NOT SUBMIT the APE Pt. 2 for American Samoa, Guam, U.S. Virgin Islands, Canada, Northern Mariana Islands and other alien jurisdictions.

APE Pt. 2 requires certain adjustments in all accounts to obtain the correct state level assessable premium with emphasis in both the allocated and unallocated annuity accounts. All lines for all columns must be completed for all states in which your company is licensed or had business during the survey year. Deductions related to unallocated annuity contracts MUST be detailed on Lines 14 through 21, where appropriate.

Certain line items pertain only to specific states (Iowa, Kansas, Louisiana, Minnesota and New Jersey) and must be completed accordingly.

Line 11 – Assessable Premium Base – Part 1

The amount from Line 10 of the APE Pt. 1 should be transferred to Line 11 of the APE Pt. 2.

Line 12.1-12.2 – Enter amounts received in excess of $1 million (Line 12.1) or $5 million (Line 12.2) for multiple non-group policies of life insurance owned by one owner (commonly referred to as “COLI/BOLI”) whether the policy or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons regardless of the number of policies and contracts held by the owner.

Line 13.1-13.99 – Enter amounts received for certain accident & health policies. Lines 13.5 (stop loss) and 13.6 (MEWA, ASO etc.) should only apply to the extent the plan or program is self-funded or uninsured.

Line 14 – All amounts related to annuities issued in connection with plans qualified under IRC Section 403(b) (“403(b) premiums”) (both allocated and unallocated) should be included in Column 2 (Allocated Annuity and Other Allocated Fund Deposits) on the APE Pt. 1 presuming your transfers on APE Pt. 1 Line 4.1 are done correctly. These amounts must be transferred to Column 4 (Unallocated Annuity and Other Unallocated Fund Deposits) in order to include the 403(b) premiums for allocated annuities in Column 4 for certain states that have not adopted the most recent account structure. The amount to be transferred from Column 2 to Column 4 represents the amount of 403(b) premiums for allocated annuity contracts ONLY to the extent included in Lines 10 of APE Pt. 1 and 11 of APE Pt. 2. Those companies that originally reported these 403(b) premiums in Column 2 of the APE Pt. 1 must transfer such amounts to Column 4 even though no original transfer was required on APE Pt. 1 Line 4.1. Enter in Column 2 a negative amount and Column 4 a corresponding positive amount (both amounts must be the same).

The total for Line 14 Columns 2 and 4 should equal zero (0) in all states.

Line 15.1-15.6 – Companies that have unallocated funding obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer (commonly referred to as “synthetic GICs”) must report such amounts on the applicable Line 15. Lines 15.1, 15.2 and 15.3 are mutually exclusive.

Lines 15.5 and 15.6 need to be completed (respectively) for Minnesota and New Jersey business only.
Line 15.3 should only include those amounts in excess of $5 million. For example, for a $15 million contract providing a book value accounting guaranty, the company should report $1 million on Line 15.1, $4 million on Line 15.2 and $10 million on Line 15.3.

Lines 16.1-16.3 – Companies that have unallocated funding obligations that are not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery must report such amounts on the applicable Line 16. An example of an appropriate Line 16 deduction would be amounts received to fund a municipal guaranteed investment contract (commonly referred to as “Muni-GICs”). Line 16.3 applies to New Jersey business only.

Lines 17.1-18.2 – Companies that have an annuity contract issued to fund government lotteries or in connection with a specific employee, union, or association of natural persons benefit plans that are NOT: (a) governmental retirement plans established under IRC Sections 401, 403(b) or 457, or (b) plan protected by the Federal Pension Benefit Guaranty Corporation must report such amounts on the applicable Lines 17 or 18. Lines 17.1, 17.2 and 17.3 are mutually exclusive.

Lines 17.5 to 18.2 need to be completed (respectively) for Minnesota (line 17.5), New Jersey (line 18.1) and Iowa (Line 18.2) business only. Like the example in Line 15, Line 17.3 should only include those amounts in excess of $5 million. As mentioned on APE Pt. 1 Line 3, for those contracts that have annuitized, the Company should report a deduction of $5 million on APE Pt. 2 Line 17.3 in Column 4 in the second or subsequent years. For additional details, please refer to the instructions for lines APE Pt. 1 Lines 3.1-3.99.

Lines 19.1-19.8 – Premium, funds or considerations related to unallocated annuities that fund governmental retirement benefit plans qualified under IRC Sections 401, 403(b) and 457 are included in APE Pt. 1 Line 10 and APE Pt. 2 Line 11, Column 2. They must be transferred to Column 4 before certain unallocated deductions can be taken. For all such premiums, funds or considerations enter in Column 2 a negative amount and in Column 4 a corresponding positive amount (both amounts must be the same). Lines 19.1, 19.2 and 19.3 are mutually exclusive. Like the example in Line 15, Line 19.3 should only include those amounts in excess of $5 million.

Lines 19.5 and 19.6 need to be completed (respectively) for Minnesota and New Jersey business only.

For Louisiana, Line 19.7 should include only amounts related to unallocated annuities issued in connection with governmental retirement benefit plans qualified under IRC Section 403(b). Report all such amounts as a positive in Column 4.

For Kansas, Line 19.8 should include only amounts related to unallocated annuities issued in connection with governmental deferred compensation plans qualified under IRC Section 457. Report all such amounts as a positive in Column 2.

Lines 20.1-20.2 – Companies that have unallocated annuity contracts issued to an employee benefit plan protected by the Federal Pension Benefit Guaranty Corporation must report such amounts on Lines 20.1 and 20.2. Employee benefit plans protected by the PBGC are defined benefit plans only and do not include defined contribution plans.
Line 7.3 Allows a deduction for unallocated annuity premiums in excess of $5 million for unallocated government lotteries and for any unallocated employee, union or association of natural persons benefit plans that is not: (a) governmental retirement plan established under Sections 401, 403(b) or 457 of the U.S. Internal Revenue Code or (b) protected under the Federal Pension Benefit Guaranty Corporation. Line 7.3 should only include those amounts in excess of $5 million. For example, for a $15 million guaranteed investment contract issued to an employee benefit plan, the company should report $10 million (i.e., amounts in excess of $5 million) on Line 7.3. Do not include on Lines 7.1, 7.2 or 7.3 amounts that have been reported as transfers or deductions on any other lines (e.g., Lines 4.2, 6, 7.1, 7.2 or 7.3).

Line 8 Enter dividends and experience rating credits, but only if such amounts were not guaranteed in advance. Examples of items that might be reported on Line 8 include: (i) non-guaranteed amounts that constitute a return of premiums collected in the current year and paid out of divisible surplus; and (ii) non-guaranteed experience rating credits that were not already deducted in determining Lines 1 and 2. Excess interest should not be deducted as dividends.

Line 21 – Lines 9.01 – 9.99 Enter any other deductible amounts with a clear explanation of the nature of such deduction on Lines 219.01, 219.02, 219.03, etc. An example of an appropriate deduction is experience rating refunds (Column 3 but only if reported as premium income) or annuitization activity to avoid double counting premiums (Column 2 or 4 of the premiums received for the Federal Employee Health Benefits Plan contracts in the Accident and Health column (Column 3). Deductions are not permitted for premiums received for the Federal Employee Group Life Insurance. Line 219 should not be used as a substitute for deductions that are to be reported on any of the above lines. Deductions are not permitted in the first three columns for amounts received in excess of coverage limits specified in the Guaranty Laws (i.e., a reporting entity cannot deduct amounts received or contract values in excess of $250/100,000 related to allocated annuity contracts).

Line 22 – Represents the assessable premium base for all states – see state specific formula.

NOTE: Cross check for APE Pt. 2 Column 4

The aggregate amounts on APE Pt. 2 Lines 15.4, 16.2, 17.4, and 20.2 should equal APE Pt. 2 Line 11, Column 4.

Model Act Base

Line 11 equals Line 5 minus Line 10.
ADJUSTMENTS TO THE
LIFE, HEALTH AND ANNUITY GUARANTY ASSOCIATION
MODEL ACT ASSESSMENT BASE RECONCILIATION EXHIBIT

Introduction

The purpose of the Adjustments to the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (Adjustments Exhibit) is to collect premium information needed by State Guaranty Associations to make assessments. The Adjustments Exhibit must be prepared with the same care and accuracy that would be used in preparing the Annual Statement, since the information is being provided to the Guaranty Fund Associations.

These instructions are intended to assist companies in completing the Adjustments Exhibit. Represents the assessable premium base. If a company is unsure if it is a member of a life, health and annuity guaranty association, it should contact the state life, health and annuity guaranty associations in its state of domicile or state(s) where it is licensed to write life, health and annuity business.

The Adjustments Exhibit has four columns: Column 1 is for all individual and group life insurance premiums; Column 2 is for all individual and group allocated annuity amounts (whether called premiums, deposits, or considerations); Column 3 is for all individual and group accident and health premiums; and Column 4 is for all unallocated annuity amounts (whether called premiums, deposits or considerations). However, the Adjustments Exhibit requires annuity information only for states – see state that have not adopted the most recent Life and Health Insurance Guaranty Association Model Act (#520). Companies are required to complete each line of the Adjustments Exhibit for all states, District of Columbia and Puerto Rico in which they were licensed or had business during the reporting year, except for those states that use the Base Reconciliation Exhibit for their respective assessment premium base (these states may be identified by referring to the respective assessment premium base formulas). DO NOT SUBMIT the Adjustments Exhibit for American Samoa, Guam, U.S. Virgin Islands, Canada, Northern Mariana Islands and other alien jurisdictions. If your company writes only life and/or accident and health insurance, there is no need to submit the Adjustments Exhibit. If you enter any miscellaneous adjustment your company may have to life and accident and health business on Line 9 of the Base Exhibit pursuant to the applicable instructions.

Adjustments to the Base Reconciliation Exhibit

All Lines (except Lines 5.3, 6.4 and 9) of Column 4 (Unallocated Annuity Considerations and Other Unallocated Fund Deposits) and Line 2 of Column 2 (Allocated Annuity and Other Allocated Fund Deposits) must be completed for all states in which your company is licensed or did business during the survey year, except for those states that use the Base Reconciliation Exhibit for their respective assessment premium base. (These states may be identified by referring to the respective assessment premium base formulas.) DO NOT SUBMIT the Adjustments Exhibit for American Samoa, Guam, U.S. Virgin Islands, Canada, Northern Mariana Islands and other alien jurisdictions.

Deductions related to unallocated annuity contracts MUST be detailed on Lines 3 through 9, where appropriate. Deductions on Line 10 related to amounts received on unallocated annuity contracts WILL NOT be allowed.

Line 1 ———— Model Act Base

The amount from Line 11 of the Base Reconciliation Exhibit should be transferred to Line 1 of the Adjustments Exhibit.
Line 2 — All 403(b) annuities are included in Column 4 (Unallocated Annuity and Other Unallocated Fund Deposits) on the Base Reconciliation Exhibit and must be transferred to Column 2 (Allocated Annuity and Other Allocated Fund Deposits) for certain states that have not adopted the most recent Model #520 in its entirety. The amount to be transferred from Column 4 to Column 2 represents the amount of 403(b) annuity premiums included in Line 1 of the Adjustments Exhibit, regardless of whether it was originally reported in Column 2 or Column 4 of the Base Reconciliation Exhibit. Those companies that originally reported 403(b) premiums in Column 4 of the Base Reconciliation Exhibit must transfer such amounts to Column 2 even though no original transfer was required on Line 4.1 of the Base Reconciliation Exhibit.

Lines 3.1 and 3.2 — Companies that have unallocated funding obligations that are not issued to or in connection with a specific formula employee, union or association of natural persons benefit plan or government lottery (Line 7.1 of the Base Reconciliation Exhibit) must report such amounts on Lines 3.1 and 3.2. Line 3.2 should include any amounts reported on Line 3.1.

Lines 4.1, 4.2, 4.3 and 4.5 — Companies that have unallocated funding obligations issued to fund government lotteries or employee, union or association of natural persons benefit plans that are NOT: (a) governmental retirement plans established under Sections 401, 403(b) or 457 of the U.S. Internal Revenue Code, or (b) protected by the Federal Pension Benefit Guaranty Corporation must report such amounts on Lines 4.1, 4.2 and 4.3. Line 4.4 equals the sum of Lines 4.1, 4.2 and 4.3. Lines 4.1, 4.2 and 4.3 are mutually exclusive. Line 4.5 needs to be completed for Minnesota business only.

Lines 5.1, 5.2, 5.3 and 5.4 — Companies that have unallocated funding obligations issued to fund governmental retirement plans established under Sections 401 and 457 of the U.S. Internal Revenue Code must report such amounts on Lines 5.1, 5.2 and 5.3. Line 5.2 should include the amounts reported on Line 5.1. Line 5.3 needs to be completed for New Jersey business only. Line 5.4 needs to be completed for Minnesota business only.

Lines 6.1, 6.2, 6.4 and 6.5 — Companies that have unallocated funding obligations issued to fund governmental retirement plans established under Section 403(b) of the U.S. Internal Revenue Code must report such amounts on Lines 6.1 and 6.2. Line 6.3 equals the sum of Lines 6.1 and 6.2. Lines 6.1 and 6.2 are mutually exclusive. Line 6.4 needs to be completed for New Jersey business only. Line 6.5 needs to be completed for Minnesota business only.

Lines 7.1, 7.2, 7.3 and 7.2 — Companies that have unallocated annuity contracts issued to an employee benefit plan protected by the Federal Pension Benefit Guaranty Corporation (Line 7.2 of the Base Reconciliation Exhibit) must report such amounts on Lines 7.1 and 7.2. Line 7.2 should include the amounts reported on Line 7.1. Line 7.3 needs to be completed for New Jersey business only.

Line 8 — Companies that have unallocated funding obligations issued to fund government lotteries must report such amounts up to $5 million per contract holder. This line should be completed for New Jersey business only. Line 9 — Companies that have unallocated funding obligations that fund employee or association of natural persons benefit plans in New Jersey in excess of $2 million need to report receipts up to $5 million per contract. This line should be completed for New Jersey business only.
Line 10 ———— Aggregate Write-ins for Other Deductions

Enter the total of the write-ins listed in schedule "Details of Write-ins Aggregated at Line 10 for Other Deductions."

Line 11 ———— Represents the preliminary assessment base calculation for those states that have not adopted the most recent Model #520.

Details of Write-ins Aggregated at Line 10 for Other Deductions

The company must provide a clear explanation of the amounts included on Line 10. Amounts deducted on any other lines on the Base Reconciliation Exhibit or Adjustments Exhibit should not be reported here, since to do so would amount to a duplicate deduction. Line 10 should not be used as a substitute for deductions that are to be reported on any of the above lines. In addition, deductions are not permitted in the first three columns for amounts received in excess of coverage limitations specified in the Guaranty Laws (e.g., a reporting entity cannot deduct amounts received or contract values in excess of $100,000 related to allocated annuity contracts).

NOTE: ——— Cross check for Adjustments Exhibit Lines 3.2, 4.3 and 7.2, Column 4

The aggregate amounts on Adjustments Exhibit Lines 3.2, 4.3 and 7.2 should equal the aggregate of the amounts on Base Exhibit Lines 7.1, 7.2 and 7.3 less the amount reported on Base Exhibit Line 3.3.
### Development of Assessable Premiums, Considerations and Deposits

#### Before Additional Adjustments

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<td>2.1</td>
<td>Contract fees for variable contracts with guarantees</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>Reporting entity contributions to employee benefits plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>Dividends or refunds applied to purchase paid-up additions and annuities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4</td>
<td>Dividends or refunds applied to shorten endowment or premium paying period</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5</td>
<td>Premium and annuity considerations waived under disability or other contract provisions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.6</td>
<td>Aggregate write-ins for other considerations, if any</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.99</td>
<td>Total (Lines 2.1 through 2.6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Amounts, if applicable, that were deducted prior to determining amounts included in Lines 1 and 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>Transfers to guaranteed Separate Accounts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2</td>
<td>Roll over of GICs or annuities into other companies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3</td>
<td>Surrenders or other benefits paid out</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4</td>
<td>Excess interest credited to accounts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5</td>
<td>Aggregate write-ins for other amounts deducted prior to determining amounts included in Lines 1 or 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.99</td>
<td>Total (Lines 3.1 through 3.5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Transfers between Columns 2 and 4 (Note: allocated governmental retirement plans established under Sections 401, 403(b) or 457 are to be transferred on Line 4.1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>Enter in Column 2, as a positive negative number, and Column 4, as a negative positive number, the total—of all ALLOCATED contracts issued to fund both governmental and non-governmental retirement plans (or its trustee) established under Sections 401, 403(b) or 457 of the U.S. Internal Revenue Code, that are included in Column 2, Lines 1, 2.99 and 3.99</td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>4.2</td>
<td>Enter in Column 2, as a positive number, and Column 4 as a negative number, the total of all UNALLOCATED contracts issued to fund ONLY governmental retirement plans (or its trustee) established under Sections 401, 403(b) or 457 of the U.S. Internal Revenue Code</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3</td>
<td>Enter in Column 2, as a positive number, and Column 4, as a negative number, the total of all other amounts reported in Column 2, Lines 1, 2.99 and 3.99 that are unallocated, other than amounts that fund unallocated contracts established under Sections 401, 403(b) or 457 of the U.S. Internal Revenue Code</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.4</td>
<td>Enter in Column 4, as a positive number, and Column 2 as a negative number, the total, of all amounts reported in Column 2, Lines 1, 2.99 and 3.99 that are unallocated, other than amounts that fund unallocated contracts established under Sections 401, 403(b) or 457 of the U.S. Internal Revenue Code</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.99</td>
<td>Total (Lines 4.1 through 4.4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Development of Amounts Included in Lines 1 Through 5 That Should Be Deducted in Determining the BASE for THE BASE Prior to Additional Adjustments

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Non-guaranteed separate account business in which the aggregate write-in amounts for portions of policies or contracts NOT guaranteed or under which the entire investment risk is borne by the policyholder (Please specify such deductions and indicate where such amounts were reported in the Annual Statement)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Current year amounts received as part of the Federal Home Loan Bank program BUT ONLY IF included in Line 5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Current year amounts received for supplemental contracts and retained asset programs BUT ONLY IF included in Line 5 and if any prior year original premiums were reported as assessable premiums.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Amounts NOT allocated to individuals or individual certificate holders or amounts received for such contracts in excess of limits.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 7. Unallocated funding obligations that do NOT fund government lotteries or employee, union, or association of natural persons benefit plans XXX XXX XXX

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>XXX</th>
<th>XXX</th>
<th>XXX</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>Unallocated funding obligations that do NOT fund government lotteries or employee, union, or association of natural persons benefit plans</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>7.2</td>
<td>Unallocated funding obligations that fund any employee, union or association of natural persons benefit plan protected by the Federal Pension Benefit Guaranty Corporation</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>7.3</td>
<td>Unallocated funding obligations that fund governmental lottery or employee, union, or association of natural persons benefit plan in excess of $5 million per contract which are NOT:</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td></td>
<td>(a) government retirement plan established under Section 401, 403(b) or 457 of the U.S. Internal Revenue Code, or (b) protected by the Federal Pension Benefit Guaranty Corporation</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>7.4</td>
<td>Total (Lines 7.1 + 7.2)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>

98. Dividends-Experience rating credits paid or credited, but only if NOT guaranteed in advance. Include only amounts NOT already deducted in determining Lines 1 and 2

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>XXX</th>
<th>XXX</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Aggregate write-ins for Other Deductions</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>10</td>
<td>Total (Lines 9 + 14)</td>
<td>XXX</td>
<td>XXX</td>
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</tbody>
</table>

### PART 2 (LINE 5 – LINE 10)

#### ASSESSABLE PREMIUM MODEL ACT BASE BEFORE ADDITIONAL ADJUSTMENTS IN PART 2 (LINE 5 – LINE 10)

#### DETAILS OF WRITE-INS

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>XXX</th>
<th>XXX</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.601</td>
<td>Summary of remaining write-ins for Line 3.5 from overflow page</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>2.602</td>
<td>Total (Lines 2.601 through 2.603) plus 2.698 (Line 3.5 above)</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>2.698</td>
<td>Summary of remaining write-ins for Line 3.5 from overflow page</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>3.501</td>
<td>Total (Lines 3.501 through 3.503) plus 3.598 (Line 3.5 above)</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>3.502</td>
<td>Summary of remaining write-ins for Line 3.5 from overflow page</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>3.503</td>
<td>Total (Lines 3.501 through 3.503) plus 3.598 (Line 3.5 above)</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>3.599</td>
<td>Total (Lines 3.501 through 3.503) plus 3.598 (Line 3.5 above)</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>0601</td>
<td>Summary of remaining write-ins for Line 6 from overflow page</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>0602</td>
<td>Total (Lines 0601 through 0603) plus 0608 (Line 6 above)</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>0603</td>
<td>Summary of remaining write-ins for Line 6 from overflow page</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>0608</td>
<td>Total (Lines 0601 through 0603) plus 0608 (Line 6 above)</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>0901</td>
<td>Summary of remaining write-ins for Line 8 from overflow page</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>0902</td>
<td>Total (Lines 0901 through 0903) plus 0908 (Line 8 above)</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>0903</td>
<td>Summary of remaining write-ins for Line 8 from overflow page</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>0908</td>
<td>Total (Lines 0901 through 0903) plus 0908 (Line 8 above)</td>
<td>XXX</td>
<td>XXX</td>
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</tbody>
</table>

Footnote 1: For purposes of allocating Long Term Care ("LTC") costs involving an insolvent company, please indicate the premium associated with standalone Disability Income ("DI" - include both short and long term) and Long Term Care business included in Line 10, Column 3. Note DI and LTC premium associated with a rider that is attached to a life or annuity policy should NOT be included.

1 a) Disability Income (include both short and long term) XXX XXX XXX

1 b) Long-term care XXX XXX XXX

Footnote 2: For purposes of all billed assessment inquiries, please indicate the individual for each state that the guaranty association should contact regarding assessment inquiries (billing, payment, etc.)

<table>
<thead>
<tr>
<th>Individual name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Department</th>
<th>Street address</th>
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<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>City, State ZIP</th>
<th>Direct phone number</th>
<th>Email address</th>
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<tbody>
<tr>
<td></td>
<td></td>
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</table>
Direct Business in the State of

<table>
<thead>
<tr>
<th>AMOUNTS REQUIRED TO DETERMINE THIS STATE’S ASSESSMENT BASE</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Premium received for multiple non-group policies of life insurance owned by one owner:</td>
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<td></td>
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<tr>
<td>12.1 Amounts in excess of $1 million</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>12.2 Amounts in excess of $5 million</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>13. Medicare Part D stand alone plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.1 Federal Employees Health Benefit Program</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>13.2 Medicare Part D stand alone plans</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>13.3 Medicaid Title XIX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>13.4 Medicaid Title XIX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>13.5 Stop loss contracts</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
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<tr>
<td>13.6 MEWA, AOS, minimum premium group plans to the extent these plans are self-funded or uninsured</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
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<tr>
<td>13.7 State Children’s Health Insurance Program Title XIX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>13.99 Total (Lines 13.1 through 13.7)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>14. Enter in Column 2, as a negative number, and Column 4, as a positive number, the total of all amounts included in Column 2, Line 11 above that have been received to fund ALLOCATED contracts established under Section 403(b) of the U.S. Internal Revenue Code, include both governmental and non-governmental plans that are included in Column 4, Line 1 above</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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</tr>
<tr>
<td>15. Amounts received from obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, in which case it is not an affiliate of the member insurer:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>15.1 Amounts NOT in excess of $1 million per contract</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>15.2 Amounts in excess of $5 million per contract</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
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<tr>
<td>15.3 Amounts in excess of $5 million per contract</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>15.4 Total (Lines 15.1 + 15.2 + 15.3)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
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<tr>
<td>15.5 Amounts NOT in excess of $10 million per contract (Minnesota only)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>15.6 Amounts in excess of $2 million per contract (New Jersey only)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>16. Amounts not allocated with a fund government lottery or specific employee, or association of natural persons benefit plans:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.1 Amounts in excess of $1 million per contract</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>16.2 Amounts in excess of $2 million per contract</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>17. Unallocated funding obligations issued to or in connection with a fund government lottery or specific employee, or association of natural persons benefit plans based on the resident of the owner, or a specific employee, union, or association of natural persons benefit plans, based on the principal place of business of the plan sponsor, which are NOT: (a) governmental retirement plans established under Sections 401, 403(b) or 457 of the U.S. Internal Revenue Code, or (b) protected by the Federal Pension Benefit Guaranty Corporation:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.1 Amounts in excess of $1 million per contract</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>17.2 Amounts in excess of $5 million per contract</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>17.3 Amounts in excess of $2 million per contract</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>17.4 Total (Lines 17.1 + 17.2 + 17.3)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>17.5 Amounts up to $10 million per contract (Minnesota only)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
</tbody>
</table>

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| 19.2 | Amounts NOT in excess of $1 million but NOT in excess of $5 million per contract | XXX | XXX | XXX | ———— |
| 19.3 | Amounts NOT in excess of $2 million per contract | XXX | XXX | XXX | ———— |
| 19.4 | Amounts NOT in excess of $10 million | XXX | XXX | XXX | ———— |
| 19.5 | Amounts NOT in excess of $51 million | XXX | XXX | XXX | ———— |
| 19.6 | Amounts in excess of $1 million but NOT in excess of $5 million per contract (New Jersey only) | XXX | XXX | XXX | ———— |
| 19.7 | Amounts in excess of $2 million per contract (New Jersey only) | XXX | XXX | XXX | ———— |
| 19.8 | Amounts in excess of $5 million per contract (New Jersey only) | XXX | XXX | XXX | ———— |
| 19.9 | All amounts | XXX | XXX | XXX | ———— |
| 19.10 | Amounts in excess of $2 million per contract (Minnesota only) | XXX | XXX | XXX | ———— |
| 19.11 | All amounts (include amounts reported on Line 20.1) | XXX | XXX | XXX | ———— |
| 20.1 | All amounts (include amounts reported on Line 20.1) | XXX | XXX | XXX | ———— |
| 20.2 | Amounts NOT in excess of $5 million per contract | XXX | XXX | XXX | ———— |
| 20.3 | Amounts NOT in excess of $5 million per contract | XXX | XXX | XXX | ———— |
| 20.4 | Amounts NOT in excess of $5 million per contract (New Jersey only) | XXX | XXX | XXX | ———— |
| 20.5 | Amounts NOT in excess of $2 million per contract (New Jersey only) | XXX | XXX | XXX | ———— |
| 20.6 | All amounts (include amounts reported on Line 20.1) | XXX | XXX | XXX | ———— |
| 20.7 | Amounts in excess of $1 million per contract | XXX | XXX | XXX | ———— |
| 20.8 | Amounts NOT in excess of $10 million per contract | XXX | XXX | XXX | ———— |
| 20.9 | Amounts NOT in excess of $51 million | XXX | XXX | XXX | ———— |
| 20.10 | Amounts in excess of $2 million per contract (Minnesota only) | XXX | XXX | XXX | ———— |
| 20.11 | Amounts in excess of $10 million | XXX | XXX | XXX | ———— |
| 20.12 | Amounts in excess of $51 million | XXX | XXX | XXX | ———— |
| 20.13 | All amounts | XXX | XXX | XXX | ———— |
| 21.1 | Amounts NOT in excess of $1 million | XXX | XXX | XXX | ———— |
| 21.2 | All amounts | XXX | XXX | XXX | ———— |
| 21.3 | Amounts NOT in excess of $2 million per contract (New Jersey only) | XXX | XXX | XXX | ———— |
| 21.4 | Amounts NOT in excess of $5 million per contract | XXX | XXX | XXX | ———— |
| 21.5 | Amounts NOT in excess of $51 million | XXX | XXX | XXX | ———— |
| 21.6 | Amounts NOT in excess of $2 million per contract (Minnesota only) | XXX | XXX | XXX | ———— |
| 21.7 | Amounts NOT in excess of $10 million | XXX | XXX | XXX | ———— |
| 21.8 | Amounts NOT in excess of $51 million | XXX | XXX | XXX | ———— |
| 21.9 | All amounts | XXX | XXX | XXX | ———— |

**OVERFLOW PAGE FOR WRITE-INS**

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## ANNUAL STATEMENT BLANK – LIFE

### SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

**MARCH FILING**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?</td>
<td></td>
</tr>
<tr>
<td>2. Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?</td>
<td></td>
</tr>
<tr>
<td>3. Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?</td>
<td></td>
</tr>
<tr>
<td>4. Will an actuarial opinion be filed by March 1?</td>
<td></td>
</tr>
</tbody>
</table>

**APRIL FILING**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Will Management’s Discussion and Analysis be filed by April 1?</td>
<td></td>
</tr>
<tr>
<td>6. Will the Life, Health &amp; Annuity Guaranty Association ASSESSABLE PREMIUM Model Act Assessment Base Reconciliation Exhibit – Parts 1 and 2 be filed with the state of domicile and the NAIC by April 1?</td>
<td></td>
</tr>
</tbody>
</table>

**JUNE FILING**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Will the Supplemental Investment Risks Interrogatories be filed by April 1?</td>
<td></td>
</tr>
<tr>
<td>8. Will an audited financial report be filed by June 1?</td>
<td></td>
</tr>
<tr>
<td>9. Will Accountants Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?</td>
<td></td>
</tr>
</tbody>
</table>

**AUGUST FILING**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Will the regulator-only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC (as a regulator-only non-public document) by August 1?</td>
<td></td>
</tr>
</tbody>
</table>

The following supplemental reports are required to be filed as part of your annual statement filing if your company is engaged in the type of business covered by the supplement. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

**MARCH FILING**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1? (Not applicable to fraternal benefit societies)</td>
<td></td>
</tr>
<tr>
<td>12. Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?</td>
<td></td>
</tr>
<tr>
<td>13. Will the Trusteed Surplus Statement be filed with the state of domicile and the NAIC by March 1?</td>
<td></td>
</tr>
<tr>
<td>14. Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 to Exhibit 5 be filed with the state of domicile and electronically with the NAIC by March 1?</td>
<td></td>
</tr>
<tr>
<td>15. Will the actuarial opinion on non-guaranteed elements as required in interrogatory #3 to Exhibit 5 be filed with the state of domicile and electronically with the NAIC by March 1?</td>
<td></td>
</tr>
<tr>
<td>16. Will the actuarial opinion on X-Factors be filed with the state of domicile and electronically with the NAIC by March 1?</td>
<td></td>
</tr>
<tr>
<td>17. Will the actuarial opinion on Separate Accounts Funding Guaranteed Minimum Benefit be filed with the state of domicile and electronically with the NAIC by March 1?</td>
<td></td>
</tr>
<tr>
<td>18. Will the actuarial opinion on Synthetic Guaranteed Investment Contracts be filed with the state of domicile and electronically with the NAIC by March 1?</td>
<td></td>
</tr>
<tr>
<td>19. Will the Reasonableness of Assumptions Certification required by Actuarial Guideline XXXV be filed with the state of domicile and electronically with the NAIC by March 17?</td>
<td></td>
</tr>
<tr>
<td>20. Will the Reasonableness and Consistency of Assumptions Certification required by Actuarial Guideline XXXV be filed with the state of domicile and electronically with the NAIC by March 17?</td>
<td></td>
</tr>
<tr>
<td>21. Will the Reasonableness of Assumptions Certification for Implied Guaranteed Rate Method required by Actuarial Guideline XXXVI be filed with the state of domicile and electronically with the NAIC by March 17?</td>
<td></td>
</tr>
<tr>
<td>22. Will the Reasonableness and Consistency of Assumptions Certification required by Actuarial Guideline XXXVI (Updated Average Market Value) be filed with the state of domicile and electronically with the NAIC by March 17?</td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>Question</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2423</td>
<td>Will the Reasonableness and Consistency of Assumptions Certification required by Actuarial Guideline XXXVI (Updated Market Value) be filed with the state of domicile and electronically with the NAIC by March 1?</td>
</tr>
<tr>
<td>2424</td>
<td>Will the C-3 RBC Certifications required under C-3 Phase I be filed with the state of domicile and electronically with the NAIC by March 1?</td>
</tr>
</tbody>
</table>

**SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES**

<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>2425</td>
<td>Will the C-3 RBC Certifications required under C-3 Phase II be filed with the state of domicile and electronically with the NAIC by March 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2426</td>
<td>Will the Actuarial Certifications Related to Annuity Nonforfeiture Ongoing Compliance for Equity Indexed Annuities be filed with the state of domicile and electronically with the NAIC by March 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2427</td>
<td>Will the actuarial opinion required by the Modified Guaranteed Annuity Model Regulation be filed with the state of domicile and electronically with the NAIC by March 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2428</td>
<td>Will the Actuarial Certification regarding the use of 2001 Preferred Class Tables required by the Model Regulation Permitting the Recognition of Preferred Mortality Tables for Use in Determining Minimum Reserve Liabilities be filed with the state of domicile and electronically with the NAIC by March 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2429</td>
<td>Will the Workers’ Compensation Carve-Out Supplement be filed by March 1? (Not applicable to fraternal benefit societies)</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2430</td>
<td>Will Supplemental Schedule O be filed with the state of domicile and the NAIC by March 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2431</td>
<td>Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2432</td>
<td>Will an approval from the reporting entity’s state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2433</td>
<td>Will an approval from the reporting entity’s state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2434</td>
<td>Will an approval from the reporting entity’s state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2435</td>
<td>Will the VM-20 Reserves Supplement be filed with the state of domicile and the NAIC by March 1?</td>
<td>...........................................................................................................</td>
</tr>
</tbody>
</table>

**APRIL FILING**

<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>2436</td>
<td>Will the confidential Regulatory Asset Adequacy Issues Summary (RAAIS) required by the Valuation Manual be filed with the state of domicile by April 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2437</td>
<td>Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2438</td>
<td>Will the Credit Insurance Experience Exhibit be filed with the state of domicile and the NAIC by April 1? (Not applicable to fraternal benefit societies)</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2439</td>
<td>Will the Accident and Health Policy Experience Exhibit be filed by April 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2440</td>
<td>Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2441</td>
<td>Will the regulator only (non-public) Supplemental Health Care Exhibit’s Allocation Report be filed with the state of domicile and the NAIC by April 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2442</td>
<td>Will the confidential Actuarial Memorandum required by Actuarial Guideline XXXVIII 8D be filed with the state of domicile by April 30?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2443</td>
<td>Will the Supplemental Term and Universal Life Insurance Reinsurance Exhibit be filed with the state of domicile and the NAIC by April 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2444</td>
<td>Will the Variable Annuities Supplement be filed with the state of domicile and the NAIC by April 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2445</td>
<td>Will the confidential Executive Summary of the PBR Actuarial Report be filed with the state of domicile by April 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2446</td>
<td>Will the confidential Life Summary of the PBR Actuarial Report be filed with the state of domicile by April 1?</td>
<td>...........................................................................................................</td>
</tr>
<tr>
<td>2447</td>
<td>Will the confidential Variable Annuities Summary of the PBR Actuarial Report be filed with the state of domicile by April 1?</td>
<td>...........................................................................................................</td>
</tr>
</tbody>
</table>

**AUGUST FILING**

<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>2448</td>
<td>Will Management’s Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?</td>
<td>...........................................................................................................</td>
</tr>
</tbody>
</table>

**Explanation:**

Bar code:
ANNUAL STATEMENT BLANK – HEALTH

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason, enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

MARCH FILING

1. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?
   ............................................................................
2. Will an actuarial opinion be filed by March 1?
   ............................................................................
3. Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?
   ............................................................................
4. Will the confidential Risk-based Capital Report be filed with the state of domicile, if required by March 1?
   ............................................................................

Detail Eliminated To Conserve Space

APRIL FILING

21. Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?
   ............................................................................
22. Will the Supplemental Life data due April 1 be filed with the state of domicile and the NAIC?
   ............................................................................
23. Will the Supplemental Property/Casualty Insurance Expense Exhibit due April 1 be filed with any state that requires it, and, if so, the NAIC?
   ............................................................................
24. Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?
   ............................................................................
25. Will the regulator-only (non-public) Supplemental Health Care Exhibit’s Allocation Report be filed with the state of domicile and the NAIC by April 1?
   ............................................................................
26. Will the Life, Health & Annuity Guaranty Association ASSESSABLE PREMIUM Model Act Assessment Base Reconciliation Exhibit Parts 1 and 2 be filed with the state of domicile and the NAIC by April 1?
   ............................................................................
27. Will the Adjustments to the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (if required) be filed with the state of domicile and the NAIC by April 1?
   ............................................................................

AUGUST FILING

27. Will Management’s Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?
   ............................................................................

Explanation:

Bar code:
### ANNUAL STATEMENT BLANK – PROPERTY

#### SUPPLEMENTAL EXHIBITS AND SCHEDULES

#### INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason, enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

<table>
<thead>
<tr>
<th>MARCH FILING</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Will an actuarial opinion be filed by March 1?</td>
<td></td>
</tr>
<tr>
<td>2. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?</td>
<td></td>
</tr>
<tr>
<td>3. Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?</td>
<td></td>
</tr>
<tr>
<td>4. Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?</td>
<td></td>
</tr>
</tbody>
</table>

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**Detail Eliminated To Conserve Space**

<table>
<thead>
<tr>
<th>APRIL FILING</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. Will the Credit Insurance Experience Exhibit be filed with the state of domicile and the NAIC by April 1?</td>
<td></td>
</tr>
<tr>
<td>30. Will the Long-term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?</td>
<td></td>
</tr>
<tr>
<td>31. Will the Accident and Health Policy Experience Exhibit be filed by April 1?</td>
<td></td>
</tr>
<tr>
<td>32. Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?</td>
<td></td>
</tr>
<tr>
<td>33. Will the regulator-only (non-public) Supplemental Health Care Exhibit’s Allocation Report be filed with the state of domicile and the NAIC by April 1?</td>
<td></td>
</tr>
<tr>
<td>34. Will the Cybersecurity and Identity Theft Insurance Coverage Supplement be filed with the state of domicile and the NAIC by April 1?</td>
<td></td>
</tr>
<tr>
<td>35. Will the Life, Health &amp; Annuity Guaranty Association ASSESSABLE PREMIUM Model Act Assessment Base Reconciliation Exhibit – Parts 1 and 2 be filed with the state of domicile and the NAIC by April 1?</td>
<td></td>
</tr>
<tr>
<td>36. Will the Adjustments to the Life, Health &amp; Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (if required) be filed with the state of domicile and the NAIC by April 1?</td>
<td></td>
</tr>
<tr>
<td>37. Will the Private Flood Insurance Supplement be filed with the state of domicile and the NAIC by April 1?</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>AUGUST FILING</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>38. Will Management’s Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?</td>
<td></td>
</tr>
</tbody>
</table>

**Explanation:**

**Bar Code:**

W:\National Meetings\2021\Spring\TF\App\BlanksWG\minutes\Att A4_2020-31BWG.docx
Blanks (E) Working Group  
Editorial Revisions to the Blanks and Instructions  
*(presented at the December 16, 2020, Meeting)*

Statement Type:  
- **H** = Health;  
- **L/F** = Life/Fraternal Combined;  
- **P/C** = Property/Casualty;  
- **SA** = Separate Accounts;  
- **T** = Title

<table>
<thead>
<tr>
<th>Effective</th>
<th>Table Name</th>
<th>Description</th>
<th>Statement Type</th>
<th>Filing Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>Long-Term Care Form 5</td>
<td><strong>CHANGE TO INSTRUCTION</strong></td>
<td>H, L/F, P/C</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Add the requirement to include a grand total page back into the instructions</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>at end of first paragraph for Form 5.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Form 5 provides LTC sales and claims experience on a state-by-state basis.</td>
<td></td>
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<td></td>
<td></td>
<td>These are the state’s portion of a number of statistics reported on a</td>
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<td></td>
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<td>nationwide basis elsewhere in these experience forms. Form 5 also includes</td>
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<td></td>
<td>data on products that include extension of and/or acceleration of LTC</td>
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<tr>
<td></td>
<td></td>
<td>benefits on life policies or annuity contracts. In addition, a schedule</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>must be prepared that contains the grand total (GT) for the company.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>Notes to Financial</td>
<td><strong>CHANGE TO INSTRUCTION</strong></td>
<td>L/F</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>Statements</td>
<td>Add the below back to Note 33. The instruction for 33F was deleted by mistake</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>but the illustration for 33F remained. The instructions were part of the</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2019-21BWG adopted by the BWG that modified the disclosure.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>**F. Reconcile total life insurance reserves amount disclosed to the</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>appropriate sections of the Aggregate Reserves for Life Policies and</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Contracts Exhibit (Exhibit 5) of the Life, Accident and Health Annual</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Statement and the corresponding lines in the Separate Accounts Statement.</td>
<td></td>
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<td></td>
<td></td>
<td>The reconciliation is a single presentation including all amounts from the</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>sections on Individual Life Insurance and Group Life Insurance.</td>
<td></td>
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</tr>
<tr>
<td>Effective</td>
<td>Table Name</td>
<td>Description</td>
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<tr>
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<td>-----------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
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</tr>
<tr>
<td>2021</td>
<td>Schedule D, Part 4</td>
<td><strong>CHANGE TO INSTRUCTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Add the word “tendered” to reference of called bonds and prepayment penalty.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Column 18 – Realized Gain (Loss) on Disposal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>This should be the difference between the Consideration column amount and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>the Book/Adjusted Carrying Value at Disposal Date, excluding any portion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>that is attributable to foreign exchange differences.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>For SVO Identified Funds (Bond Mutual Funds and Exchange Traded Funds),</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>enter the difference between the consideration, Column 7 and actual cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Column 9 at date of sale.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bonds called or tendered where consideration received exceeds par:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For securities sold, redeemed or otherwise disposed of, which generate</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>investment income as a result of a prepayment penalty and/or acceleration</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>fee, the amount of realized gain (loss) reported is equal to the Par value</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>of the investment (Column 8) less the BACV at the Disposal Date (Column 16).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bonds called or tendered where consideration received is less than par:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For securities sold, redeemed or otherwise disposed of, the amount of</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>investment income and realized gain reported shall be calculated in</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>accordance with SSAP No. 26R—Bonds.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement Type</th>
<th>Filing Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>H, L/F, P/C, T</td>
<td>Annual</td>
</tr>
</tbody>
</table>
### Table Name
Schedule D, Part 4

#### Description
**CHANGE TO INSTRUCTION**

<table>
<thead>
<tr>
<th>Effective</th>
<th>Table Name</th>
<th>Description</th>
</tr>
</thead>
</table>
| 2021      | Schedule D, Part 4 | Add the word “tendered” to reference of called bonds and prepayment penalty.  

**Column 20**
Bond Interest/Stock Dividends Received During Year

For Mutual Funds (including Bond Mutual Funds – as Identified by the SVO and Exchange Traded Funds – as Identified by the SVO), enter the amount of distributions received in cash or reinvested in additional shares. Include: The proportionate share of investment income, directly related to the securities reported in this schedule.

Report amounts net of foreign withholding tax.

Bonds called or tendered where consideration received exceeds par:

- For securities sold, redeemed or otherwise disposed of, which generate investment income as a result of a prepayment penalty and/or acceleration fee; the amount of investment income reported is equal to the total consideration received (Column 7) less the Par value of the investment (Column 8).

Bonds or tendered called where consideration received is less than par:

- For securities sold, redeemed or otherwise disposed of, the amount of investment income and realized gain reported shall be calculated in accordance with SSAP No. 26R—Bonds.
<table>
<thead>
<tr>
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<td>Annual</td>
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<td></td>
<td>Add the word “tendered” to reference of called bonds and prepayment penalty.</td>
<td>H, L/F, P/C, T</td>
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<td>Column 18 – Realized Gain (Loss) on Disposal</td>
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<td>This should be the difference between the Consideration column amount and the Book/Adjusted Carrying Value at Disposal Date, excluding any portion that is attributable to foreign exchange differences.</td>
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<td>Bonds called or tendered where consideration received exceeds par:</td>
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<td>For securities sold, redeemed or otherwise disposed of, which generate investment income as a result of a prepayment penalty and/or acceleration fee; the amount of realized gain (loss) reported is equal to the Par value of the investment (Column 8) less the BACV at the Disposal Date (Column 11).</td>
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<td>Bonds called or tendered where consideration received is less than par:</td>
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<td>For securities sold, redeemed or otherwise disposed of, the amount of investment income and realized gain reported shall be calculated in accordance with SSAP No. 26R—Bonds.</td>
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<td>Add the word “tendered” to reference of called bonds and prepayment penalty.</td>
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<td>Column 20 – Interest and Dividends Received During Year</td>
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<td>For Mutual Funds (including Bond Mutual Funds – as Identified by the SVO and Exchange Traded Funds – as Identified by the SVO), enter the amount of distributions received in cash or reinvested in additional shares.</td>
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<td>Include: The proportionate share of investment income directly related to the securities reported in this schedule.</td>
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<td>Report amounts net of foreign withholding tax.</td>
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<td>Bonds called or tendered where consideration received exceeds par:</td>
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<td>For securities sold, redeemed or otherwise disposed of, which generate investment income as a result of a prepayment penalty and/or acceleration fee, the amount of investment income reported is equal to the total consideration received (Column 10) less the Par value of the investment (Column 8).</td>
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<td>Bonds called or tendered where consideration received is less than par:</td>
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| 2021     | Schedule D, Part 4       | **CHANGE TO INSTRUCTION**  
Add the word “tendered” to reference of called bonds and prepayment penalty.  
Column 18 – Realized Gain or (Loss) on Disposal  
This should be the difference between the Consideration column amount and the Book/Adjusted Carrying Value at Disposal Date, excluding any portion that is attributable to foreign exchange differences.  
For Bond Mutual Funds – as identified by the SVO and Exchange Traded Funds – as identified by the SVO, enter the difference between the consideration, Column 7 and actual cost Column 9 at date of sale.  
Bonds called or tendered where consideration received exceeds par:  
For securities sold, redeemed or otherwise disposed of, which generate investment income as a result of a prepayment penalty and/or acceleration fee; the amount of realized gain (loss) reported is equal to the Par value of the investment (Column 8) less the BACV at the Disposal Date (Column 16).  
Bonds called or tendered where consideration received is less than par:  
For securities sold, redeemed or otherwise disposed of, the amount of investment income and realized gain reported shall be calculated in accordance with SSAP No. 26R—Bonds. | H, L/F, P/C, T | Quarterly |
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<td>Add the word “tendered” to reference of called bonds and prepayment penalty.</td>
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<td>Column 20 – Bond Interest/Stock Dividends Received During Year</td>
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<td>For Mutual Funds (including Bond Mutual Funds – as Identified by the SVO and Exchange Traded Funds – as Identified by the SVO), enter the amount of distributions received in cash or reinvested in additional shares.</td>
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<td>For securities sold, redeemed or otherwise disposed of, which generate investment income as a result of a prepayment penalty and/or acceleration fee; the amount of investment income reported is equal to the total consideration received (Column 7) less the Par value of the investment (Column 8).</td>
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<td>Notes to Financial Statements</td>
<td><strong>CHANGE TO INSTRUCTION</strong></td>
<td>H, L/F, P/C, T</td>
<td>Annual</td>
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<td>Add reference to tendered bonds to Note 5Q.</td>
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<td>Q. Prepayment Penalty and Acceleration Fees</td>
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<td>For securities sold, redeemed or otherwise disposed as a result of a callable or tender offer feature (including make whole call provisions), disclose the number of CUSIPs sold, disposed or otherwise redeemed and the aggregate amount of investment income generated as a result of a prepayment penalty and/or acceleration fee for the General Account and Separate Account.</td>
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<td>2021</td>
<td>Jurat</td>
<td><strong>CHANGE TO INSTRUCTION</strong></td>
<td>H, L/F, P/C, T</td>
<td>Annual</td>
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</tbody>
</table>

Add the clarification below for signatures.

Signatures

Complete the Jurat signature requirements in accordance with the requirements of the domiciliary state. Direct any questions concerning signature requirements to that state. At least one statement filed with Consult the requirements of the domiciliary state regarding filing of the statement with must have original signatures and must be manually signed by the appropriate corporate officers with the corporate seal affixed thereon where appropriate, and be properly notarized. For statements filed in non-domestic states, facsimile signatures or reproductions of original signatures may be used except where otherwise mandated. If the appropriate corporate officers are incapacitated or otherwise not available due to a personal emergency, the reporting entity should contact the domiciliary state for direction as to who may sign the statement.

NOTE: If the United States Manager of a U.S. Branch or the Attorney-in-Fact of a Reciprocal Exchange or Lloyds Underwriters is a corporation, the affidavit should be signed by two (or three) principal officers of the corporation; or, if a partnership, by two (or three) of the principal members of the partnership.

For domiciliary jurisdictions that require the reporting entity to submit signatures on the Jurat page as part of the PDF filed with the NAIC see the instructions for submitting a signed Jurat in the General Electronic Filing Directive. The link to that directive can be found at the following Web address:

[www.naic.org/cmte_e_app_blanks.htm](http://www.naic.org/cmte_e_app_blanks.htm)
<table>
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<th>Description</th>
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<tbody>
<tr>
<td>2022</td>
<td>Jurat</td>
<td>CHANGE TO INSTRUCTION</td>
</tr>
</tbody>
</table>

Add the clarification below for signatures.

**Signatures**

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www.naic.org/cmte_e_app_blanks.htm
# NAIC BLANKS (E) WORKING GROUP

## Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>Jacob W. Garn</th>
</tr>
</thead>
<tbody>
<tr>
<td>TITLE:</td>
<td>Chair, Blanks Working Group</td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
<td>AFFILIATION:</td>
</tr>
<tr>
<td>ADDRESS:</td>
<td>NAME:</td>
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</tbody>
</table>

**DATE:** 11/03/2020

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## BLANK(S) TO WHICH PROPOSAL APPLIES

<table>
<thead>
<tr>
<th>ANNUAL STATEMENT</th>
<th>QUARTERLY STATEMENT</th>
<th>INSTRUCTIONS</th>
<th>CROSSCHECKS</th>
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<td>[ X ]</td>
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</table>

**Anticipated Effective Date:** Annual 2021

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## IDENTIFICATION OF ITEM(S) TO CHANGE

Add a new Health Care Receivables Supplement to the Life/Fraternal Annual Statement that adds Exhibits 3 and 3A from the Health Annual Statement to the to the Life/Fraternal annual filings. Add guidance document reference to Exhibit 3A of the Health Annual Statement.

---

## REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of the proposal is to allow for more consistency of reporting between the life and health blanks with regards to health care receivables. The addition is intended to provide regulators with detailed health care receivables information from life companies that write a large amount of health business to allow for analysis at the nationwide level.

---

## NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

** This section must be completed on all forms.  
Revised 7/18/2018
ANNUAL STATEMENT INSTRUCTIONS – HEALTH

EXHIBIT 3A – ANALYSIS OF HEALTH CARE RECEIVABLES

The purpose of this exhibit is to analyze health care receivables collected and accrued for the current year compared to the prior year.

This exhibit is based on the gross health care receivable, not just the admitted portion.

Report the total asset (health care receivable) in this exhibit not just the admitted portion. Amounts are gross of reinsurance.

Refer to SSAP No. 84—Health Care and Government Insured Plan Receivables for accounting guidance. [See reporting guidance at [**INSERT WEB ADDRESS WHEN GUIDANCE POSTED**].

In this exhibit, the term “accrued” is analogous to the term “incurred” on the U&I Exhibit, Part 2B. Accrued pertains to the health care receivable asset, whereas incurred pertains to the claim liability.

ANNUAL STATEMENT INSTRUCTIONS – LIFE\FRATERNAL

HEALTH CARE RECEIVABLES SUPPLEMENT

The Health Care Receivables Supplement shall be completed by those companies reporting accident and health business.

This supplement is required to be filed no later than March 1.

EXHIBIT 3 – HEALTH CARE RECEIVABLES

Individually list the greater of any account balances greater than $10,000 or those that are 10% of gross health care receivables. Use Lines 0100001 through 0699996, as needed. Report gross amounts for insured plans although these amounts may be offset against corresponding liabilities on the balance sheet. Report the aggregate of amounts not individually listed on Lines 0199998 through 0699998. The subtotal and grand total amounts should be reported on the following lines:

<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
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</thead>
<tbody>
<tr>
<td>Pharmaceutical Rebate Receivables</td>
<td>0199999</td>
</tr>
<tr>
<td>Claim Overpayment Receivables</td>
<td>0299999</td>
</tr>
<tr>
<td>Loans and Advances to Providers</td>
<td>0399999</td>
</tr>
<tr>
<td>Capitation Arrangement Receivables</td>
<td>0499999</td>
</tr>
<tr>
<td>Risk sharing Receivables</td>
<td>0599999</td>
</tr>
<tr>
<td>Other Receivables</td>
<td>0699999</td>
</tr>
<tr>
<td>Gross Health Care Receivables</td>
<td>0799999</td>
</tr>
</tbody>
</table>

Column 7 — Admitted

Total line should equal the inset amount on Line 24 of the Asset Page.
EXHIBIT 3A – ANALYSIS OF HEALTH CARE RECEIVABLES

The purpose of this exhibit is to analyze health care receivables collected and accrued for the current year compared to the prior year.

This exhibit is based on the gross health care receivable, not just the admitted portion.

Report the total asset (health care receivable) in this exhibit not just the admitted portion. Amounts are gross of reinsurance.

Refer to SSAP No. 84—Health Care and Government Insured Plan Receivables for accounting guidance. (See reporting guidance at [**INSERT WEB ADDRESS WHEN GUIDANCE POSTED**].

Columns 1 and 2:

Enter separately in Columns 1 and 2, Lines 1 through 6, all amounts collected or offset during the year accrued prior to the current year and accrued during the current year. Record only those amounts actually collected including offsets, that meet the offset conditions of SSAP No. 64—Offsetting and Netting of Assets and Liabilities.

Line 3 includes amounts charged against those gross health care receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider as the claims have not been paid as of the statement date.

All amounts collected, including offsets, related to prior year receivables accrued should be reported in Column 1. All amounts collected, including offsets, related to current year receivables accrued should be reported in Column 2.

Columns 3 and 4:

Enter separately in Columns 3 and 4 the gross health care receivables accrual amount between those accrued prior to the current year and those accrued during the year. All amounts accrued related to prior year receivables accrued should be reported in Column 3. All amounts accrued related to current year receivables accrued should be reported in Column 4.

For each of Lines 1 through 7, the sum of Columns 3 through 4 should agree to Exhibit 3 Health Care Receivables, sum of Columns 6 and 7, for each type of health care receivable and in total.

Column 5:

Enter the sum of Columns 1 and 3. This is the amount collected or offset during the current year on health care receivables that were accrued prior to the current year, plus amounts still accrued at the end of the current year, related to the health care receivable accrued at the end of the prior year.

Column 6:

Column 6 reports the amounts of prior year-end accounting accrual for gross health care receivables.

The comparison between Columns 5 and 6 is to the total receivables, not just the portion that is an admitted asset.
## EXHIBIT 3 – HEALTH CARE RECEIVABLES

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</tr>
</tbody>
</table>
## HEALTH CARE RECEIVABLES SUPPLEMENT

**EXHIBIT 3A – ANALYSIS OF HEALTH CARE RECEIVABLES COLLECTED AND ACCRUED**

<table>
<thead>
<tr>
<th>Type of Health Care Receivable</th>
<th>Health Care Receivables Collected During the Year</th>
<th>Health Care Receivables Accrued as of December 31 of Current Year</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>On Amounts Accrued Prior to January 1 of Current Year</td>
<td>On Amounts Accrued During the Year</td>
<td>On Amounts Accrued December 31 of Prior Year</td>
<td>On Amounts Accrued During the Year</td>
</tr>
<tr>
<td>1. Pharmaceutical rebate receivables</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Claim overpayment receivables</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Loans and advances to providers</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. Capitation arrangement receivables</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5. Risk sharing receivables</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6. Other health care receivables</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Totals (Lines 1 through 6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note that the accrued amounts in Columns 3, 4 and 6 are the total health care receivables, not just the admitted portion.
SUPPLEMENTAL EXHIBITS AND SCHEDULES
INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

MARCH FILING

25. Will the C-3 RBC Certifications required under C-3 Phase I be filed with the state of domicile and electronically with the NAIC by March 1?

36. Will the VM-20 Reserves Supplement be filed with the state of domicile and the NAIC by March 1?

37. Will the Health Care Receivables Supplement be filed with the state of domicile and the NAIC by March 1?

APRIL FILING

38. Will the confidential Regulatory Asset Adequacy Issues Summary (RAAIS) required by the Valuation Manual be filed with the state of domicile by April 1?

39. Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?

40. Will the Credit Insurance Experience Exhibit be filed with the state of domicile and the NAIC by April 1? (Not applicable to fraternal benefit societies)

41. Will the Accident and Health Policy Experience Exhibit be filed by April 1?

42. Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?

43. Will the regulator only (non-public) Supplemental Health Care Exhibit’s Allocation Report be filed with the state of domicile and the NAIC by April 1?

44. Will the confidential Actuarial Memorandum required by Actuarial Guideline XXXVIII 8D be filed with the state of domicile by April 30?

45. Will the Supplemental Term and Universal Life Insurance Reinsurance Exhibit be filed with the state of domicile and the NAIC by April 1?

46. Will the Variable Annuities Supplement be filed with the state of domicile and the NAIC by April 1?

47. Will the confidential Executive Summary of the PBR Actuarial Report be filed with the state of domicile by April 1?

48. Will the confidential Life Summary of the PBR Actuarial Report be filed with the state of domicile by April 1?

49. Will the confidential Variable Annuities Summary of the PBR Actuarial Report be filed with the state of domicile by April 1?

AUGUST FILING

50. Will Management’s Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?

Explanation:

Bar code:

W:\National Meetings\2021\Spring\TF\App\BlanksWG\minutes\Att_B_2020-32BWG.doc
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>DATE: 11/05/2020</th>
</tr>
</thead>
<tbody>
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<tr>
<td>EMAIL ADDRESS:</td>
<td></td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
<td></td>
</tr>
<tr>
<td>NAME:</td>
<td>Justin C. Schrader</td>
</tr>
<tr>
<td>TITLE:</td>
<td>Chief Financial Examiner</td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td>Nebraska Department of Insurance</td>
</tr>
<tr>
<td>ADDRESS:</td>
<td>1135 M St. Ste. 300, Lincoln, NE 68501-2089</td>
</tr>
</tbody>
</table>

FOR NAIC USE ONLY

Agenda Item # 2020-33BWG MOD

Year  2021-2022

Changes to Existing Reporting [ X ]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [ X ]
Modifies Required Disclosure [ ]

DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ X ] Adopted Date 03/16/2021
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT [ X ] INSTRUCTIONS [ X ] CROSSCHECKS
[ X ] QUARTERLY STATEMENT [ X ] BLANK

[ ] Life, Accident & Health/Fraternals
[ X ] Property/Casualty
[ ] Health
[ ] Separate Accounts
[ ] Protected Cell
[ ] Title
[ ] Other ___________________

Anticipated Effective Date: Annual 2021 1st Quarter 2022

IDENTIFICATION OF ITEM(S) TO CHANGE

Modify Annual Statement Lines (ASLs) used on Underwriting and Investment (U&I) Exhibits, State Page and Insurance Expense Exhibit (IEE). Change Health ASL categories used in Property to be consistent with other statement types. Update ASL references used in crosschecks. Update definitions used in the appendix for the Health ASLs. See next page for details.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of the proposal is to provide consistency in the granularity of reporting of ASLs on the U&I pages, IEE and State Page and consistency in Health ASLs used across statement types. See next page for details.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: _____________________________

Other Comments: _____________________________________________

** This section must be completed on all forms.

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IDENTIFICATION OF ITEM(S) TO CHANGE

Modify the Annual Statement Line (ASL) numbers on the Underwriting and Investment Exhibits, State Page and Insurance Expense Exhibit to show the same ASL numbers. Make the same modification to the Quarterly Part 1 and Part 2.

Eliminate Interrogatory Questions 1 for the Insurance Expense Exhibit Interrogatories.

Change the Health ASL categories to match the Lines of Business (LOB) categories used in the Health and Life\Fraternal statements. Add the appropriate LOB definitions for those lines to the Lines of Business definitions in the appendix of the annual statement instructions.

Modify the ASL references in the State Page and Insurance Expense Exhibit instructions to reflect additions of ASL numbers to the Underwriting and Investment Exhibits, State Page and Insurance Expense Exhibit.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The differences in line titles and degree of granularity between schedules results in difficulty cross-comparing information from one schedule to another. For example, “Allied” is reported as a single line on the Underwriting and Investment Exhibit – Part 1B Premiums Written while the Exhibit of Premiums and Losses (EPL) reports, “Allied Lines,” “Multiple Peril Crop,” “Federal Flood,” “Private Crop,” and “Private Flood” all as separate components of “Allied.” The level of granularity on the EPL should be carried throughout the financial blank to ensure consistency in the review of the data across schedules.

Changing the Health ASL categories to match the Lines of Business (LOB) categories used in the Health and Life\Fraternal statements brings consistency of the LOB categories used in reporting in Health, Life\Fraternal and Property.
### ANNUAL STATEMENT BLANK – PROPERTY

Underwriting & Investment Exhibit I Parts 1, 1A, 1B, 2, and 2A

<table>
<thead>
<tr>
<th>Line of Business</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fire</td>
<td>2.1 Allied lines</td>
</tr>
<tr>
<td>2.2 Multiple peril crop</td>
<td>2.3 Federal flood</td>
</tr>
<tr>
<td>2.4 Private crop</td>
<td>2.5 Private flood</td>
</tr>
<tr>
<td>3. Farmowners multiple peril</td>
<td>4. Homeowners multiple peril</td>
</tr>
<tr>
<td>5.1 Commercial multiple peril (non-liability portion)</td>
<td>5.2 Commercial multiple peril (liability portion)</td>
</tr>
<tr>
<td>11.1 Medical professional liability—occurrence</td>
<td>11.2 Medical professional liability—claims-made</td>
</tr>
<tr>
<td>12. Earthquake</td>
<td>13.1 Comprehensive (hospital and medical) individual</td>
</tr>
<tr>
<td>13.2 Comprehensive (hospital and medical) group, accident and health</td>
<td>15.1 Vision only/Other accident and health</td>
</tr>
<tr>
<td>15.2 Dental only</td>
<td>15.3 Disability income</td>
</tr>
<tr>
<td>15.4 Medicare supplement</td>
<td>15.5 Medicare title XIX</td>
</tr>
<tr>
<td>15.6 Medicare title XVIII</td>
<td>15.7 Long-term care</td>
</tr>
<tr>
<td>15.8 Federal employees health benefits plan premium</td>
<td>15.9 Other health</td>
</tr>
<tr>
<td>16. Workers’ compensation</td>
<td>17.1 Other liability—occurrence</td>
</tr>
<tr>
<td>17.2 Other liability—claims-made</td>
<td>17.3 Excess workers’ compensation</td>
</tr>
<tr>
<td>18.1 Products liability—occurrence</td>
<td>18.2 Products liability—claims-made</td>
</tr>
<tr>
<td>19.1 Private passenger auto liability</td>
<td>19.2 Other private passenger auto liability</td>
</tr>
<tr>
<td>19.3 Commercial auto liability</td>
<td>19.4 Other commercial auto liability</td>
</tr>
<tr>
<td>19.5 Commercial auto non-fault (personal injury protection)</td>
<td>20.1 Private passenger auto no-fault (personal injury protection)</td>
</tr>
<tr>
<td>21.2 Commercial auto physical damage</td>
<td>22. Aircraft (all perils)</td>
</tr>
<tr>
<td>22. Aircraft (all perils)</td>
<td>23. Fidelity</td>
</tr>
<tr>
<td>24. Surety</td>
<td>25. Burglary and theft</td>
</tr>
<tr>
<td>26. Boiler and machinery</td>
<td>27. Credit</td>
</tr>
<tr>
<td>28. Credit</td>
<td>29. International</td>
</tr>
<tr>
<td>30. Warranty</td>
<td>31. Reinsurance-nonproportional assumed property</td>
</tr>
<tr>
<td>32. Reinsurance-nonproportional assumed liability</td>
<td>33. Reinsurance-nonproportional assumed financial lines</td>
</tr>
<tr>
<td>34. Aggregate write-ins for other lines of business</td>
<td>35. TOTALS</td>
</tr>
</tbody>
</table>

#### DETAILS OF WRITE-INS

<table>
<thead>
<tr>
<th>Line</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>3401</td>
<td>Totals (Lines 3401 through 3403 plus 3498) (Line 34 above)</td>
</tr>
<tr>
<td>3402</td>
<td></td>
</tr>
<tr>
<td>3403</td>
<td></td>
</tr>
<tr>
<td>3404</td>
<td></td>
</tr>
<tr>
<td>3498</td>
<td>Sum. of remaining write-ins for Line 34 from overflow page</td>
</tr>
<tr>
<td>3499</td>
<td></td>
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</table>

© 2021 National Association of Insurance Commissioners
### Insurance Expense Exhibit Parts II and III

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<thead>
<tr>
<th>Order</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>Fire</td>
</tr>
<tr>
<td>2.1</td>
<td>Allied Lines</td>
</tr>
<tr>
<td>2.2</td>
<td>Multiple Peril Crop</td>
</tr>
<tr>
<td>2.3</td>
<td>Federal Flood</td>
</tr>
<tr>
<td>2.4</td>
<td>Private Crop</td>
</tr>
<tr>
<td>2.5</td>
<td>Private Flood</td>
</tr>
<tr>
<td>3.</td>
<td>Farmowners Multiple Peril</td>
</tr>
<tr>
<td>4.</td>
<td>Homeowners Multiple Peril</td>
</tr>
<tr>
<td>5.1</td>
<td>Commercial Multiple Peril (Non-Liability Portion)</td>
</tr>
<tr>
<td>5.2</td>
<td>Commercial Multiple Peril (Liability Portion)</td>
</tr>
<tr>
<td>6.</td>
<td>Mortgage Guaranty</td>
</tr>
<tr>
<td>7.</td>
<td>Ocean Marine</td>
</tr>
<tr>
<td>8.</td>
<td>Inland Marine</td>
</tr>
<tr>
<td>9.</td>
<td>Fire Insurance Expense Exhibit Parts II and III</td>
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<td>10.</td>
<td>Financial Guaranty</td>
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<tr>
<td>11.1</td>
<td>Medical Professional Liability—Occurrence</td>
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<tr>
<td>11.7</td>
<td>Medical Professional Liability—Claims-Made</td>
</tr>
<tr>
<td>12.</td>
<td>Disaster</td>
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<tr>
<td>13.1</td>
<td>Comprehensive Hospital and Medical—Individual</td>
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<tr>
<td>13.2</td>
<td>Comprehensive Hospital and Medical—Group</td>
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<tr>
<td>14.</td>
<td>Credit A&amp;H</td>
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<td>15.1</td>
<td>Vision Only Other A&amp;H (See Interrogatory 1)</td>
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<tr>
<td>15.2</td>
<td>Dental Only</td>
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<td>15.3</td>
<td>Disability Income</td>
</tr>
<tr>
<td>15.4</td>
<td>Medicare Supplement</td>
</tr>
<tr>
<td>15.5</td>
<td>Medicare Title XIX</td>
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<tr>
<td>15.6</td>
<td>Medicare Title XVII</td>
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<td>15.7</td>
<td>Long-Term Care</td>
</tr>
<tr>
<td>15.8</td>
<td>Federal Employees Health Benefits Plan (FEHBP) Premium</td>
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<tr>
<td>15.9</td>
<td>Other Health</td>
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<td>16.</td>
<td>Workers’ Compensation</td>
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<tr>
<td>17.1</td>
<td>Other Liability—Occurrence</td>
</tr>
<tr>
<td>19.1</td>
<td>Private Passenger Auto No-Fault (Personal Injury Protection)</td>
</tr>
<tr>
<td>19.2</td>
<td>Private Passenger Auto Liability</td>
</tr>
<tr>
<td>19.3</td>
<td>Commercial Auto No-Fault (Personal Injury Protection)</td>
</tr>
<tr>
<td>19.4</td>
<td>Other Commercial Auto Liability</td>
</tr>
<tr>
<td>20.1</td>
<td>Private Passenger Auto Physical Damage</td>
</tr>
<tr>
<td>20.2</td>
<td>Commercial Auto Physical Damage</td>
</tr>
<tr>
<td>22.</td>
<td>Aircraft (all perils)</td>
</tr>
<tr>
<td>23.</td>
<td>Fidelity</td>
</tr>
<tr>
<td>24.</td>
<td>Surety</td>
</tr>
<tr>
<td>26.</td>
<td>Burglary and Theft</td>
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<td>27.</td>
<td>Boiler and Machinery</td>
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<td>Credit</td>
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<td>29.</td>
<td>International</td>
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<tr>
<td>30.</td>
<td>Warranty</td>
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</tbody>
</table>

#### DETAILS OF WRITE-INS

| Line 3401 | Summary of remaining write-ins for Line 34 from overflow page |
| Line 3402 | |
| Line 3403 | |
| Line 3409 | Total (Lines 3401 through 3403 plus 3498) |

**DRAFTING NOTE:** ASL 31, 32 and 33 would be X’d out for Part III (ALLOCATION TO LINES OF DIRECT BUSINESS WRITTEN) of the Insurance Expense Exhibit.
### Exhibit of Premiums and Losses (Statutory Page 14)

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Details of Write-Ins</th>
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<tbody>
<tr>
<td>1. Fire</td>
<td>3499. TOTAL (Lines 3401 through 3403 plus 3498) (Line 34 above)</td>
</tr>
<tr>
<td>2.1 Allied Lines</td>
<td>3498. Summary of remaining write-ins for Line 34 from overflow page</td>
</tr>
<tr>
<td>2.2 Multiple Peril Crop</td>
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</tr>
<tr>
<td>2.3 Federal Flood</td>
<td></td>
</tr>
<tr>
<td>2.4 Private Crop</td>
<td></td>
</tr>
<tr>
<td>2.5 Private Flood</td>
<td></td>
</tr>
<tr>
<td>3. Farmowners Multiple Peril</td>
<td></td>
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<tr>
<td>4. Homeowners Multiple Peril</td>
<td></td>
</tr>
<tr>
<td>5.1 Commercial Multiple Peril (Non-Liability Portion)</td>
<td></td>
</tr>
<tr>
<td>5.2 Commercial Multiple Peril (Liability Portion)</td>
<td></td>
</tr>
<tr>
<td>6. Mortgage Guaranty</td>
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</tr>
<tr>
<td>8. Ocean Marine</td>
<td></td>
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<tr>
<td>9. Inland Marine</td>
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</tr>
<tr>
<td>10. Financial Guaranty</td>
<td></td>
</tr>
<tr>
<td>11.1 Medical Professional Liability—Occurrence</td>
<td></td>
</tr>
<tr>
<td>11.3 Medical Professional Liability—Claims-Made</td>
<td></td>
</tr>
<tr>
<td>12. Earthquake</td>
<td></td>
</tr>
<tr>
<td>13.1 Comprehensive (Hospital and Medical) Individual</td>
<td></td>
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<tr>
<td>13.2 Comprehensive (Hospital and Medical) Group Accident and Health</td>
<td></td>
</tr>
<tr>
<td>14. Credit A&amp;H (Group and Individual)</td>
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</tr>
<tr>
<td>15.1 Vision Only Collectively Renewable A&amp;H(b)</td>
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</tr>
<tr>
<td>15.2 Dental Only Non-Renewable A&amp;H(b)</td>
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</tr>
<tr>
<td>15.3 Disability Income Guaranteed Renewable A&amp;H(b)</td>
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<tr>
<td>15.4 Medicare Supplement Non-Renewable for Stated Reasons Only(b)</td>
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<td>15.5 Medicaid Title XIX Other Accident Only</td>
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<td>15.6 Medicare Title XVIII Non-Exempt From State Taxes or Fees</td>
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</tr>
<tr>
<td>15.7 Long-Term Care A&amp;H (b)</td>
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<tr>
<td>15.8 Federal Employees Health Benefits Plan Premium</td>
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<td>15.9 Other Health(b)</td>
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<tr>
<td>16. Workers’ Compensation</td>
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<td>17.1 Other Liability—Occurrence</td>
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<tr>
<td>17.2 Other Liability—Claims-Made</td>
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<tr>
<td>17.3 Excess Workers’ Compensation</td>
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<td>18.1 Products Liability—Occurrence</td>
<td></td>
</tr>
<tr>
<td>18.2 Products Liability—Claims-Made</td>
<td></td>
</tr>
<tr>
<td>19.1 Private Passenger Auto No-Fault (Personal Injury Protection)</td>
<td></td>
</tr>
<tr>
<td>19.2 Other Private Passenger Auto Liability</td>
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</tr>
<tr>
<td>19.3 Commercial Auto No-Fault (Personal Injury Protection)</td>
<td></td>
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<tr>
<td>19.4 Other Commercial Auto Liability</td>
<td></td>
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<tr>
<td>20.1 Private Passenger Auto Physical Damage</td>
<td></td>
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<td>20.2 Commercial Auto Physical Damage</td>
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<td>22. Aircraft (all perils)</td>
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<tr>
<td>23. Fidelity</td>
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<tr>
<td>24. Surety</td>
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<tr>
<td>26. Burglary and Theft</td>
<td></td>
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<tr>
<td>27. Boiler and Machinery</td>
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<td>28. Credit</td>
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</tr>
<tr>
<td>29. International</td>
<td></td>
</tr>
<tr>
<td>30. Warranty</td>
<td></td>
</tr>
<tr>
<td>31. Reinsurance-Nonproportional Assumed Property</td>
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<tr>
<td>32. Reinsurance-Nonproportional Assumed Liability</td>
<td></td>
</tr>
<tr>
<td>33. Reinsurance-Nonproportional Assumed Financial Lines</td>
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<tr>
<td>34. Aggregate Write-Ins for Other Lines of Business</td>
<td></td>
</tr>
<tr>
<td>35. TOTAL(a)</td>
<td></td>
</tr>
</tbody>
</table>

**DRAFTING NOTE:** ASL 31, 32 and 33 would be X’d.
QUARTERLY STATEMENT BLANK – PROPERTY

PART 1 – LOSS EXPERIENCE and PART 2 – DIRECT PREMIUMS WRITTEN

<table>
<thead>
<tr>
<th>Line of Business</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fire</td>
<td></td>
</tr>
<tr>
<td>2.1 Allied lines</td>
<td></td>
</tr>
<tr>
<td>2.2 Multiple peril crop</td>
<td></td>
</tr>
<tr>
<td>2.3 Federal flood</td>
<td></td>
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<tr>
<td>2.4 Private crop</td>
<td></td>
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<tr>
<td>2.5 Private flood</td>
<td></td>
</tr>
<tr>
<td>3. Farmowners multiple peril</td>
<td></td>
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<tr>
<td>4. Homeowners multiple peril</td>
<td></td>
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<tr>
<td>5. Commercial multiple peril</td>
<td></td>
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<tr>
<td>6. Mortgage guaranty</td>
<td></td>
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<tr>
<td>8. Ocean marine</td>
<td></td>
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<tr>
<td>9. Inland marine</td>
<td></td>
</tr>
<tr>
<td>10. Financial guaranty</td>
<td></td>
</tr>
<tr>
<td>11.1 Medical professional liability - occurrence</td>
<td></td>
</tr>
<tr>
<td>11.2 Medical professional liability - claims made</td>
<td></td>
</tr>
<tr>
<td>12. Earthquake</td>
<td></td>
</tr>
<tr>
<td>13.1 Comprehensive (hospital and medical) individual</td>
<td></td>
</tr>
<tr>
<td>13.2 Comprehensive (hospital and medical) group accident and health</td>
<td></td>
</tr>
<tr>
<td>14. Credit accident and health</td>
<td></td>
</tr>
<tr>
<td>15. Vision only</td>
<td></td>
</tr>
<tr>
<td>15.1 Other accident and health</td>
<td></td>
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<tr>
<td>15.2 Dental only</td>
<td></td>
</tr>
<tr>
<td>15.3 Disability income</td>
<td></td>
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<tr>
<td>15.4 Medicare supplement</td>
<td></td>
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<tr>
<td>15.5 Medicaid title XIX</td>
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<tr>
<td>15.6 Medicare title XVIII</td>
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<tr>
<td>15.7 Long-term care</td>
<td></td>
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<tr>
<td>15.8 Federal employees health benefit plan premium</td>
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<tr>
<td>15.9 Other health</td>
<td></td>
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<tr>
<td>16. Workers' compensation</td>
<td></td>
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<tr>
<td>17.1 Other liability occurrence</td>
<td></td>
</tr>
<tr>
<td>17.2 Other liability - claims made</td>
<td></td>
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<tr>
<td>17.3 Excess Workers’ Compensation</td>
<td></td>
</tr>
<tr>
<td>18.1 Products liability-occurrence</td>
<td></td>
</tr>
<tr>
<td>18.2 Products liability-claims made</td>
<td></td>
</tr>
<tr>
<td>18.3 Private passenger auto liability</td>
<td></td>
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<tr>
<td>18.4 Private passenger auto no-fault (personal injury protection)</td>
<td></td>
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<tr>
<td>18.5 Other private passenger auto liability</td>
<td></td>
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<tr>
<td>18.6 Other commercial auto liability</td>
<td></td>
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<tr>
<td>18.7 Commercial auto no-fault (personal injury protection)</td>
<td></td>
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<tr>
<td>18.8 Other commercial auto liability</td>
<td></td>
</tr>
<tr>
<td>21.1 Private passenger auto - physical damage</td>
<td></td>
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<tr>
<td>21.2 Commercial auto - physical damage</td>
<td></td>
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<tr>
<td>22. Aircraft (all perils)</td>
<td></td>
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<tr>
<td>23. Fidelity</td>
<td></td>
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<tr>
<td>24. Surety</td>
<td></td>
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<tr>
<td>26. Burglary and theft</td>
<td></td>
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<tr>
<td>27. Boiler and machinery</td>
<td></td>
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<tr>
<td>28. Credit</td>
<td></td>
</tr>
<tr>
<td>29. International</td>
<td></td>
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<tr>
<td>30. Warranty</td>
<td></td>
</tr>
<tr>
<td>31. Reinsurance-Nonproportional Assumed Property</td>
<td></td>
</tr>
<tr>
<td>32. Reinsurance-Nonproportional Assumed Liability</td>
<td></td>
</tr>
<tr>
<td>33. Reinsurance-Nonproportional Assumed Financial Lines</td>
<td></td>
</tr>
<tr>
<td>34. Aggregate write-ins for other lines of business</td>
<td></td>
</tr>
</tbody>
</table>

DETAILED WRITE-INS

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3401</td>
<td>Totals (Lines 3401 through 3403 plus 3498) (Line 34)</td>
</tr>
</tbody>
</table>
INSURANCE EXPENSE EXHIBIT
For The Year Ended December 31, 2021
(To Be Filed by April 1)

INTERROGATORIES

1. Change in reserve for deferred maternity and other similar benefits are reflected in:
   1.1 Premiums Earned ........................................................................................................... [ ]
   1.2 Losses Incurred ........................................................................................................... [ ]
   1.3 Not Applicable ........................................................................................................... [ ]

21. Indicate amounts received from securities subject to proration for federal tax purposes. Report amounts in whole dollars only:
   21.1 Amount included on Exhibit of Net Investment Income, Line 1.1, Column 2 .................... $......................................
   21.2 Amount included on Exhibit of Net Investment Income, Line 2.1, Column 2 .................... $......................................
   21.3 Amount included on Exhibit of Net Investment Income, Line 2.11, Column 2 ................. $......................................
   21.4 Amount included on Exhibit of Net Investment Income, Line 2.2, Column 2 .................... $......................................
   21.5 Amount included on Exhibit of Net Investment Income, Line 2.21, Column 2 ................. $......................................

32. Indicate amounts shown in the Annual Statement for the following items. Report amounts in whole dollars only:
   32.1 Net Investment Income, Page 4, Line 9, Column 1 .......................................................... $......................................
   32.2 Net realized Capital Gain or (Loss), Page 4, Line 10, Column 1 ....................................... $......................................

43.1 The information provided in the Insurance Expense Exhibit will be used by many persons to estimate the allocation of expenses and profit to the various lines of business. Are there any items requiring special comment or explanation? Yes [ ] No [ ]

43.2 Are items allocated to lines of business in Parts II and III using methods not defined in the instructions? Yes [ ] No [ ]

43.3 If yes, explain: ........................................................................................................ .......................................

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**ANNUAL STATEMENT INSTRUCTIONS – PROPERTY**

**EXHIBIT OF PREMIUMS AND LOSSES**

**DIRECT BUSINESS IN THE STATE OF...**

*(Statutory Page 14 Data)*

---

**Column 1 – Direct Premiums Written**

The amounts reported on the GT (Grand Total) Page for the lines in this column should agree with the amounts reported for the identical line in Column 1 of the Underwriting and Investment Exhibit, Part 1B, with the following exceptions:

- The sum of Lines 2.1, 2.2, 2.3, 2.4 and 2.5 should equal Underwriting and Investment Exhibit, Part 1B, Column 1, Line 2.
- The sum of Lines 5.1 and 5.2 should equal Underwriting and Investment Exhibit, Part 1B, Column 1, Line 5.
- Line 11 should equal the sum of Lines 11.1 and 11.2, Underwriting and Investment Exhibit, Part 1B, Column 1.
- The sum of Lines 15.1 through 15.8 should equal Underwriting and Investment Exhibit, Part 1B, Column 1, Line 15.
- Line 18 should equal the sum of Lines 18.1 and 18.2, Underwriting and Investment Exhibit, Part 1B, Column 1.
- The sum of Lines 19.1 and 19.2 should equal Underwriting and Investment Exhibit, Part 1B, Column 1, Line 19.1 and 19.2.
- The sum of Lines 19.3 and 19.4 should equal Underwriting and Investment Exhibit, Part 1B, Column 1, Line 19.3 and 19.4.

**Column 2 – Direct Premiums Earned**

May be estimated by formula on the basis of countrywide ratios for the respective lines of business except where adjustments are required to recognize special situations.

**Column 5 – Direct Losses Paid (Deducting Salvage)**

The amounts reported on the GT (Grand Total) Page for the lines in this column should agree with the amounts reported for the identical line in Column 1 of the Underwriting and Investment Exhibit, Part 2, Column 1, with the following exceptions:

- The sum of Lines 2.1, 2.2, 2.3, 2.4 and 2.5 should equal Underwriting and Investment Exhibit, Part 2, Column 1, Line 2.
The sum of Lines 5.1 and 5.2 should equal Underwriting and Investment Exhibit, Part 2, Column 1, Line 5.

Line 11 should equal the sum of Lines 11.1 and 11.2, Underwriting and Investment Exhibit, Part 2, Column 1.

The sum of Lines 15.1 through 15.8 should equal Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.

Line 18 should equal the sum of Lines 18.1 and 18.2, Underwriting and Investment Exhibit, Part 2, Column 1.

The sum of Lines 19.1 and 19.2 should equal Underwriting and Investment Exhibit, Part 2, Column 1, Line 19.1 and 19.2.

The sum of Lines 19.3 and 19.4 should equal Underwriting and Investment Exhibit, Part 2, Column 1, Line 19.3 and 19.4.

The sum of Lines 21.1 and 21.2 should equal Underwriting and Investment Exhibit, Part 2, Column 1, Line 21.

**Column 7 — Direct Losses Unpaid**

The amounts reported on the GT (Grand Total) Page for the lines in this column should agree with the amounts reported for the identical line in Column 1 plus Column 5 of the Underwriting and Investment Exhibit, Part 2A, with the following exceptions:

The sum of Lines 2.1, 2.2, 2.3, 2.4 and 2.5 should equal Underwriting and Investment Exhibit, Part 2A, Column 1 plus Column 5, Line 2.

The sum of Lines 5.1 and 5.2 should equal Underwriting and Investment Exhibit, Part 2A, Column 1 plus Column 5, Line 5.

Line 11 should equal the sum of Lines 11.1 and 11.2, Underwriting and Investment Exhibit, Part 2A, Column 1 plus Column 5.

The sum of Lines 15.1 through 15.8 should equal Underwriting and Investment Exhibit, Part 2A, Column 1 plus Column 5, Line 15.

Line 18 should equal the sum of Lines 18.1 and 18.2, Underwriting and Investment Exhibit, Part 2A, Column 1 plus Column 5.

The sum of Lines 19.1 and 19.2 should equal Underwriting and Investment Exhibit, Part 2A, Column 1 plus Column 5, Line 19.1 and 19.2.

The sum of Lines 19.3 and 19.4 should equal Underwriting and Investment Exhibit, Part 2A, Column 1 plus Column 5, Line 19.3 and 19.4.


Detail Eliminated to Conserve Space
INTERROGATORIES

Interrogatory 4-3 shall be used to explain any item or items requiring special comment or explanation. Disclose the method of allocation for any items in Parts II and III that are not allocated by means defined in the Uniform Classification of Expenses found in the Appendix of the Annual Statement Instructions.

Part II – Allocation to Lines of Business Net of Reinsurance

For Columns 1, 3, 7, 13 and 19, the amounts reported in these columns for the individual lines should equal the amounts reported in the identical lines of annual statement schedules as referenced parenthetically below each respective column heading in the exhibit, with the following exceptions:

- The sum of IEE Lines 2.1, 2.2, 2.3, 2.4 and 2.5 should equal Line 2 of the annual statement schedules as referenced parenthetically below each respective column heading in the exhibit for Columns 1, 3, 7, 13 and 19.
- The sum of IEE Lines 5.1 and 5.2 should equal Line 5 of the annual statement schedules as referenced parenthetically below each respective column heading in the exhibit for Columns 1, 3, 7, 13 and 19.
- IEE Line 11 should equal the sum of Lines 11.1 and 11.2 of the annual statement schedules as referenced parenthetically below each respective column heading in the exhibit for Columns 1, 3, 7, 13 and 19.
- IEE Line 18 should equal the sum of Lines 18.1 and 18.2 of the annual statement schedules as referenced parenthetically below each respective column heading in the exhibit for Columns 1, 3, 7, 13 and 19.
- The sum of IEE Lines 21.1 and 21.2 should equal Line 21 of the annual statement schedules as referenced parenthetically below each respective column heading in the exhibit for Columns 1, 3, 7, 13 and 19.
- IEE Line 31, 32 and 33 should equal the sum of Lines 31, 32 and 33 of the annual statement schedules as referenced parenthetically below each respective column heading in the exhibit for Columns 1, 3, 7, 13 and 19.

Allocate by lines of business for Column 5, Dividends to Policyholders, Column 21, Agents’ Balances, Column 23, Commission and Brokerage Expenses Incurred, Column 25, Taxes, Licenses & Fees Incurred, Column 27, Other Acquisitions, Field Supervision, and Collection Expenses Incurred, Column 29, General Expenses Incurred, and Column 31, Other Income Less other Expenses.
Part III – Allocation to Lines of Direct Business Written

Detail Eliminated to Conserve Space

For Column 1, the amounts reported in the individual lines should agree with the identical lines on the Underwriting and Investment Schedule, Part 1B, Column 1, with the following exceptions:

- The sum of IEE Lines 2.1, 2.2, 2.3, 2.4 and 2.5 should equal the Underwriting and Investment Exhibit, Part 1B, Column 1, Line 2.

- The sum of IEE Lines 5.1 and 5.2 should equal the Underwriting and Investment Exhibit, Part 1B, Column 1, Line 5.

- IEE Line 11 should equal the sum of Lines 11.1 and 11.2, Underwriting and Investment Exhibit, Part 1B, Column 1.

- IEE Line 18 should equal the sum of Lines 18.1 and 18.2, Underwriting and Investment Exhibit, Part 1B, Column 1.

- The sum of IEE Lines 21.1 and 21.2 should equal the Underwriting and Investment Exhibit, Part 1B, Column 1, Line 21.
APPENDIX

PROPERTY AND CASUALTY LINES OF BUSINESS

These definitions should be applied when reporting all applicable amounts for the following schedules: Underwriting and Investment Exhibit Parts 1, 1A, 1B, 2, and 2A; Exhibit of Premiums and Losses (Statutory Page 14); and the Insurance Expense Exhibit. Policy fees, service charges or membership charges are to be included with the line of business or in Other Income, as determined by SSAP No. 53—Property Casualty Contracts – Premiums.

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**Detail Eliminated to Conserve Space**

<table>
<thead>
<tr>
<th>Line 13 – Comprehensive (Hospital and Medical)</th>
<th>Policies that provide fully insured indemnity, HMO, PPO, or Fee for Service coverage for hospital, medical, and surgical expenses. This category excludes Short-Term Medical Insurance, the Federal Employees Health Benefit Program and non-comprehensive coverage such as basic hospital only, medical only, hospital confinement indemnity, surgical, outpatient indemnity, specified disease, intensive care, and organ and tissue transplant coverage as well as any other coverage described in the other categories of this exhibit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line 14 – Credit Accident and Health</td>
<td>Coverage provided to, or offered to, borrowers in connection with a consumer credit transaction where the proceeds are used to repay a debt or an installment loan in the event the consumer is disabled as the result of an accident, including business not exceeding 120 months duration (Group and Individual).</td>
</tr>
<tr>
<td>Line 15 – Other Accident and Health</td>
<td>Accident and health coverages not otherwise properly classified as Comprehensive (Hospital and Medical) and Health or Credit Accident and Health. Include all Medicare Part D Prescription Drug Coverage, whether sold on a stand-alone basis or through a Medicare Advantage product and whether sold directly to an individual or through a group.</td>
</tr>
<tr>
<td>15.1 – Vision Only</td>
<td>Policies providing for vision only coverage issued as stand-alone vision or as a rider to a medical policy that is not related to the medical policy through premiums, deductibles or out-of-pocket limits. Does not include self-insured business, federal employees health benefit plans (FEHBP), or Medicare and Medicaid programs.</td>
</tr>
<tr>
<td>15.2 – Dental Only</td>
<td>Policies providing for dental only coverage (dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw) issued as stand-alone dental or as a rider to a medical policy that is not related to the medical policy through premiums, deductibles or out-of-pocket limits. If dental benefits are part of a comprehensive medical plan, then include data under comprehensive/major medical category. Does not include self-insured business, as well as federal employee’s health benefits plans (FEHBP), or Medicare and Medicaid programs.</td>
</tr>
</tbody>
</table>
15.3 – Disability Income

Include: Policies that provide a weekly or monthly income benefit for more than five years for individual coverage and more than one year for group coverage for full or partial disability arising from accident and/or sickness. Include policies that provide Overhead Expense Benefits. Does not include credit disability.

Policies that provide a weekly or monthly income benefit for up to five years for individual coverage and up to one year for group coverage for full or partial disability arising from accident and/or sickness. Include policies that provide Overhead Expense Benefits. Does not include credit disability.

15.4 – Medicare Supplement

Include: Policies that qualify as Medicare Supplement policy forms as defined in the NAIC Medicare Supplement Insurance Minimum Standards Model Act. This includes standardized plans, pre-standardized plans and Medicare select. Does not include Medicare (Title XVIII) or Medicaid (Title XIX) risk contracts.

15.5 – Medicaid title XIX

Include: Policies issued in association with the Federal/State entitlement program created by Title XIX of the Social Security Act of 1965 that pays for medical assistance for certain individuals and families with low incomes and resources.

15.6 – Medicare title XVIII

Include: Policies issued as Medicare Advantage Plans providing Medicare benefits to Medicare eligible beneficiaries created by title XVIII of the Social Security Act of 1965. This includes Medicare Managed Care Plans (i.e., HMO and PPO) and Medicare Private Fee-for-Service Plans. This also includes all Medicare Part D Prescription Drug Coverage through a Medicare Advantage product and whether sold directly to an individual or through a group.

15.7 – Long-Term Care

Include: Policies that provide coverage for not less than one year for diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital, including policies that provide benefits for cognitive impairment or loss of functional capacity. This includes policies providing only nursing home care, home health care, community-based care, or any combination. Do not include coverage provided under comprehensive/major medical policies, Medicare Advantage, or for accelerated death benefit-type products.
15.8 – Federal Employees Health Benefits Plan Premium

Include: Business allocable to the Federal Employees Health Benefit Plan premium that are exempted from state taxes or other fees by Section 8909(f)(1) of Title 5 of the United States Code. Does not include Medicare and Medicaid programs.

15.9 – Other Health

Include: Stop loss/excess loss and any other accident and health coverages not specifically required in Annual Statement lines 13, 14, 15.1 through 15.8.

Line 13 – Group Accident and Health

Coverage written on a group basis (e.g., employees of a single employer and their dependents) that pays scheduled benefits or medical expenses caused by disease, accidental injury or accidental death. Excludes amounts attributable to uninsured accidents and health plans and the uninsured portion of partially insured accident and health plans. Coverage is usually provided in the following manner:

A single policy called a “master contract” is issued to the group policyholder to cover a group of individuals who have a defined relationship (other than insurance) to the policyholder, such as:

- employee/employer
- member/union
- debtor/creditor

The contract provides specified types of insurance coverage for the individuals in a group. Policies generally provide benefits for one or more of the following coverages: short- or long-term disability income benefits, accidental death or dismemberment coverage, major medical expense benefits, and dental expense benefits.

Line 14 – Credit Accident and Health (Group and Individual)

Coverage provided to, or offered to, borrowers in connection with a consumer credit transaction where the proceeds are used to repay a debt or an installment loan in the event the consumer is disabled as the result of an accident, including business not exceeding 120 months duration.

Line 15 – Other Accident and Health

Accident and health coverages not otherwise properly classified as Group Accident and Health or Credit Accident and Health (e.g., collectively renewable and individual non-cancelable, guaranteed renewable, non-renewable for stated reasons only, etc.). Include all Medicare Part D Prescription Drug Coverage, whether sold on a stand-alone basis or through a Medicare Advantage product and whether sold directly to an individual or through a group.

Line 15.1 – Collectively Renewable A&H

Include: Amounts pertaining to policies that are made available to groups of persons under a plan sponsored by an employer, or an association or a union or affiliated associations or unions or a group of individuals supplying materials to a central point of collection or handling a common product or commodity, under which the reporting entity has agreed with respect to such policies that renewal will not be refused, subject to any specified age limit, while the insured remains a member of the group.
specified in the agreement unless the reporting entity simultaneously refuses renewal to all other policies in the same group. A sponsored plan shall not include any arrangement where a reporting entity’s customary individual policies are made available without special underwriting considerations and where the employer’s participation is limited to arranging for salary allotment premium payments with or without contribution by the employer. Such plans are sometimes referred to as payroll budget or salary allotment plans. A sponsored plan may be administered by an agent or trustee.

Amounts pertaining to policies issued by a company or group of companies under a plan, other than a group insurance plan, authorized by special legislation for the exclusive benefit of the aged through mass enrollment.

Amounts pertaining to policies issued under mass enrollment procedures to older people, such as those age 65 and over, in some geographic region or regions under which the reporting entity has agreed with respect to such policies that renewal will not be refused unless the reporting entity simultaneously refuses renewal to all other policies specified in the agreement.

Line 15.2 – Non-Cancelable A&H

Include: Amounts pertaining to policies, which are guaranteed renewable for life or to a specified age, such as 60 or 65, at guaranteed premium rates.

Line 15.3 – Guaranteed Renewable A&H

Include: Amounts pertaining to policies that are guaranteed renewable for life or to a specified age, such as 60 or 65, but under which the reporting entity reserves the right to change the scale of premium rates.

Line 15.4 – Non-Renewable for Stated Reasons Only

Include: Amounts pertaining to policies in which the reporting entity has reserved the right to cancel or refuse renewal for one or more stated reasons, but has agreed implicitly or explicitly that, prior to a specified time or age, it will not cancel or decline renewal solely because of deterioration of health after issue.

Line 15.5 – Other Accident Only

Include: Policies that provide coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by, or necessitated as a result of, accident or specified kinds of accidents not included in Annual Statement lines 13, 14, 15.1 through 15.4, 15.6 and 15.8. Types of coverage include student accident, sports accident, travel accident, blanket accident, specific accident or accidental death and dismemberment (AD&D).

Line 15.6 – Medicare Title XVIII Exempt from State Taxes or Fees
Report Medicare Title XVIII premiums that are exempted from state taxes or other fees by Section 1854(g) of the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This includes, but is not limited to, premiums written under a Medicare Advantage product, a Medicare PPO product or a stand-alone Medicare Part D product.

Line 15.7—All Other A&H

Include: Any other accident and health coverages not specifically required in Annual Statement lines 13, 14, 15.1 through 15.6 and 15.8.

Line 15.8—Federal Employees Health Benefits Plan Premium

Include: Premiums, dividends and losses allocable to the Federal Employees Health Benefits Plan that are exempted from state taxes or other fees by Section 8909(f)(1) of Title 5 of the U.S. Code.

Detail Eliminated to Conserve Space
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

FOR NAIC USE ONLY
Agenda Item # 2020-34BWG
Year 2021
Changes to Existing Reporting [ X ]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING
PRACTICES AND PROCEDURES IMPACT
No Impact [ X ]
Modifies Required Disclosure [ ]

DISPOSITION
[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ X ] Adopted Date 03/16/2021
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES

[ ] ANNUAL STATEMENT [ X ] INSTRUCTIONS [ ] CROSSCHECKS
[ ] QUARTERLY STATEMENT [ ] BLANK
[ ] Life, Accident & Health/Fraterna
[ ] Property/Casualty
[ X ] Health

[ ] Separate Accounts
[ ] Protected Cell
[ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2021

IDENTIFICATION OF ITEM(S) TO CHANGE

Add definitions for the Occupational Accident, Fiduciary Liability, Premises and Operations (OL&T and M&C), Professional Errors and Omissions Liability, Kidnap & Ransom Liability and Tuition Reimbursement Plans products to the appropriate Line of Business in the appendix.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to modify definitions in the Property Lines of Business Definitions section of the appendix to new product definition included in the Property Uniform Product Matrix that are not included in the definitions in the Annual Statement Instructions.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: ______________________________________

Other Comments:

** This section must be completed on all forms. Revised 7/18/2018
ANNUAL STATEMENT INSTRUCTIONS - PROPERTY

APPENDIX

PROPERTY AND CASUALTY LINES OF BUSINESS

Line 10 – Financial Guaranty
A surety bond, insurance policy, or when issued by an insurer, an indemnity contract and any guaranty similar to the foregoing types, under which loss is payable upon proof of occurrence of financial loss to an insured claimant, obligee or indemnitee as a result of failure to perform a financial obligation (see Financial Guaranty Insurance Guideline (#1626)).

Line 11 – Medical Professional Liability
Insurance coverage protecting a licensed health care provider or health care facility against legal liability resulting from the death or injury of any person due to the insured’s misconduct, negligence, or incompetence in rendering professional services. Medical Professional Liability is also known as Medical Malpractice.

Include Medical Professional Liability for:


Line 12 – Earthquake
Property coverages for losses resulting from a sudden trembling or shaking of the earth, including that caused by volcanic eruption. Excluded are losses resulting from fire, explosion, flood or tidal wave following the covered event.

Line 16 – Workers’ Compensation
Insurance that covers an employer’s liability for injuries, disability or death to persons in their employment, without regard to fault, as prescribed by state or Federal workers’ compensation laws and other statutes. Includes employer’s liability coverage against the common law liability for injuries to employees (as distinguished from the liability imposed by Workers’ Compensation Laws). Excludes excess workers’ compensation.

Alternative Workers’ Compensation
Other than standard workers’ compensation coverage, employer’s liability and excess workers’ compensation (e.g., large deductible, managed care).
Employers’ Liability

Employers’ liability coverage for the legal liability of employers arising out of injuries to employees. This line of business should be used when coverage is issued as an endorsement, or as part of a statutory workers’ compensation policy. When coverage is issued as a stand-alone policy, or as an endorsement a package policy, the appropriate “Other Liability” line of business should be used.

Standard Workers’ Compensation

Insurance that covers an employer’s liability for injuries, disability or death to persons in their employment, without regard to fault, as prescribed by state or federal workers’ compensation laws and included within the basic policy employers’ liability coverage.

Occupational Accident

Insurance that covers occupational accident to include comparable workers’ compensation.

Line 17 – Other Liability

Insurance coverage protecting the insured against legal liability resulting from negligence, carelessness or a failure to act, causing property damage or personal injury to others. Typically, coverages include construction and alteration liability; contingent liability; contractual liability; elevators and escalators liability; errors and omissions liability, environmental pollution liability; excess stop loss, excess over insured or self-insured amounts and umbrella liability; liquor liability; personal injury liability; premises and operations liability; completed operations liability, nonmedical professional liability, etc. Also includes indemnification coverage provided to self-insured employers on an excess of loss basis (excess workers’ compensation).

Completed Operations Liability

Premiums attributable to policies covering the liability of contractors, plumbers, electricians, repair shops and similar firms to persons who have incurred bodily injury or property damage from defective work or operations completed or abandoned by or for the insured, away from the insured’s premises.

Construction and Alteration Liability

Premiums attributable to policies covering the liability of an insured to persons who have incurred bodily injury or property damage from alterations involving demolition, new construction or change in size of a structure on the insured’s premises.

Contingent Liability

Premiums attributable to policies covering the liability of an insured to persons who have incurred bodily injury or property damage from work done by an independent contractor hired by the insured to perform work that was illegal, inherently dangerous, supervised too closely; or it was a situation that does not permit delegation of responsibility.
Contractual Liability

Premiums attributable to policies covering the liability of an insured that has assumed the legal liability of another party by written or oral contract. Includes coverage that names the lender/lessor as beneficiary and indemnifies the borrower/lessee for the liability of the balance due on the automobile loan/lease for an automobile that has been destroyed in an accident.

Elevators and Escalators Liability

Premiums attributable to policies covering the liability of an insured to persons who have incurred bodily injury or property damage from use of elevators or escalators operated, maintained or controlled by the insured.

Errors and Omissions Liability

Professional Liability Other Than Medical

Premiums attributable to policies covering the liability of a professional or quasi-professional insured to persons who have incurred bodily injury or property damage, or who have sustained any loss from omissions arising from the performance of services for others, errors in judgment, breaches of duty, or negligent or wrongful acts in business conduct.

Environmental Pollution Liability

Premiums attributable to policies covering the liability of an insured to persons who have incurred bodily injury or property damage from acids, fumes, smoke, toxic chemicals, waste materials or other pollutants.

Excess and Umbrella Liability

Premiums attributable to policies covering the liability of an insured above a specific amount set forth in a basic policy issued by the primary insurer; or a self-insurer for losses over a stated amount; or an insured or self-insurer for known or unknown gaps in basic coverages or self-insured retentions.

Liquor Liability

Premiums attributable to policies covering the liability of an insured to persons who have incurred bodily injury or property damage from an intoxicated person.

Personal Injury Liability

Premiums attributable to policies covering the liability of an insured to persons who have been discriminated against, falsely arrested, illegally detained, libeled, maliciously prosecuted, slandered, suffered mental anguish or alienation of affections, or have had their right of privacy violated. Includes identity theft.

Premises and Operations Liability

Premiums attributable to policies covering the liability of an insured to persons who have incurred bodily injury or property damage on an insured’s premises during normal operations or routine maintenance, or from an insured’s business operations either on or off of the insured’s premises.
Excess Workers’ Compensation

Either specific and/or aggregate excess workers’ compensation insurance written above an attachment point or self-insured retention.

Commercial General Liability

Flexible and broad commercial liability coverage with two major sub-lines: premises/operations sub-line and products/completed operations sub-line.

Comprehensive Personal Liability

Comprehensive liability coverage for exposures arising out of the residence premises and activities of individuals and family members. (Non-business liability exposure protection for individuals.)

Day Care Centers

Liability coverage for day care centers.

Directors and Officers Liability

Liability coverage protecting directors or officers of a corporation from liability arising out of the performance of their professional duties on behalf of the corporation.

Employee Benefit Liability

Liability protection for an employer for claims arising from provisions in an employee benefit insurance plan provided for the economic and social welfare of employees. Examples of items covered are pension plans, group life insurance, group health insurance, group disability income insurance, and accidental death and dismemberment.

Employers’ Liability

Employers’ liability coverage for the legal liability of employers arising out of injuries to employees. This line of business should be used when coverage is issued as a stand-alone policy, or as an endorsement to a package policy. When this coverage is issued as an endorsement to a statutory workers’ compensation policy, the “Workers’ Compensation” line of business should be used.

Employment Practices Liability

Liability protection for an employer providing personal injury coverage arising out of employment-related practices, personnel policies, acts or omissions. Examples of claims such policies respond to are refusal to employ, termination, coercion, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation and discrimination.

Fire Legal Liability

Coverage for property loss liability as the result of separate negligent acts and/or omissions of the insured that allows a spreading fire to cause bodily injury or property damage of others. An example is a tenant who, while occupying another party’s property, through negligence causes fire damage to the property.

Municipal Liability

Liability coverage for the acts of a municipality.
Nuclear Energy Liability

Coverage for bodily injury and property damage liability resulting from the nuclear energy material (whether or not radioactive) on the insured business’s premises or in transit.

Veterinarian

Liability coverage for the acts of a veterinarian.

Internet Liability

Liability arising out of claims for wrongful acts related to the content posted on a website by the insured or the insured’s failure to maintain the security of its computer systems.

Cyber Liability

Stand-alone comprehensive coverage for liability arising out of claims related to unauthorized access to or use of personally identifiable or sensitive information due to events including, but not limited to, viruses, malicious attacks, or system errors or omissions. This coverage could also include expense coverage for business interruption, breach management and/or mitigation services. When cyber liability is provided as an endorsement or as part of a multi-peril policy, as opposed to a stand-alone policy, use the appropriate annual statement line of business of the product to which the coverage will be attached.

Fiduciary Liability

This type of insurance provides protection for fiduciaries against legal liability for claims made against them for a wrongful act (defined as a breach of fiduciary duty imposed by ERISA or similar common or statutory law). It’ll respond to claims for damages arising out of improper investments, plan and employee advice, insufficient funding and failure of an insurer to perform.

Examples include failure to invest plan assets prudently or failure to select a qualified service provider for a covered plan. Some fiduciary liability policies may also provide coverage for negligent acts, as well as errors or omissions in the administration of employee benefit plans.

Premises and Operations (OL&T and M&C)

Policies covering the liability of an insured to persons who have incurred bodily injury or property damage on an insured’s premises during normal operations or routine maintenance, or from an insured’s business operations either on or off of the insured’s premises.

Professional Errors and Omissions Liability

Coverage available to pay for liability arising out of the performance of professional or business-related duties, with coverage being tailored to the needs of the specific profession. Examples include abstracters, accountants, insurance adjusters, architects, engineers, insurance agents and brokers, lawyers, real estate agents, stockbrokers.
Line 17.1 – Other Liability Occurrence

Exclude: Excess workers’ compensation included in Line 17.3.

Line 17.2 – Other Liability Claims Made

Exclude: Excess workers’ compensation included in Line 17.3.

Line 17.3 – Excess Workers’ Compensation

Include: Indemnification coverage provided to self-insured employers on an excess of loss basis.

Line 18 – Product Liability

Insurance coverage protecting the manufacturer, distributor, seller or lessor of a product against legal liability resulting from a defective condition causing personal injury, or damage, to any individual or entity, associated with the use of the product.

Line 25 – Glass

Coverage for the costs of replacement and incidental costs of building glass due to breakage or application of chemicals to glass. NOTE: This coverage should be included in Allied Lines.

Detail Eliminated to Conserve Space

Line 26 – Burglary and Theft

Coverage for property taken or destroyed by breaking and entering the insured’s premises, burglary or theft, forgery or counterfeiting, fraud, kidnap and ransom, and off-premises exposure.

Kidnap & Ransom Liability

Liability coverage up to specific limits for payments demanded by kidnappers for the release of an insured held against his or her will.

Line 27 – Boiler and Machinery

Coverage for the failure of boilers, machinery and electrical equipment. Benefits include:

(i) property of the insured that has been directly damaged by the accident.
(ii) Costs of temporary repairs and expediting expenses.
(iii) Liability for damage to the property of others.

Detail Eliminated to Conserve Space
Details for Write-ins

Coverages not generally described above.

Involuntary Unemployment Insurance

Space

Coverage of satellites, shuttles, hull, drones and other non-standard aircraft.

Political and Natural Disaster Evacuation

Coverage of specified costs for an insured person to return to their country of residence or nearest place of safety and specified reasonable accommodation costs (if the insured person is unable to return to their country of residence), as a direct result of a covered evacuation or if a natural disaster has occurred in the country the insured person is currently in requiring their immediate evacuation to avoid the risk of bodily injury or sickness, while the insured person is on a journey covered by the policy.

War Risk Insurance/War Terrorism and Political Violence

Mortgage Interest Insurance

Money Insurance

Tuition Reimbursement Plans

Product which reimburses for the tuition expenses of students who drop out, are expelled, leave for medical reasons, etc.
# NAIC BLANKS (E) WORKING GROUP

## Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>DATE:</th>
<th>11/11/2020</th>
</tr>
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<tbody>
<tr>
<td>CONTACT PERSON:</td>
<td></td>
</tr>
<tr>
<td>TELEPHONE:</td>
<td></td>
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<tr>
<td>EMAIL ADDRESS:</td>
<td></td>
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<tr>
<td>ON BEHALF OF:</td>
<td></td>
</tr>
<tr>
<td>NAME:</td>
<td>Kim Hudson</td>
</tr>
<tr>
<td>TITLE:</td>
<td></td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td>California Department of Insurance</td>
</tr>
<tr>
<td>ADDRESS:</td>
<td>300 South Spring St. Los Angeles, CA 90013</td>
</tr>
</tbody>
</table>

### FOR NAIC USE ONLY

- **Agenda Item #**: 2020-35BWG MOD
- **Year**: 2022
- **Changes to Existing Reporting**: [X]
- **New Reporting Requirement**: [ ]

### REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

- **No Impact**: [X]
- **Modifies Required Disclosure**: [ ]

### DISPOSITION

- [ ] Rejected For Public Comment
- [ ] Referred To Another NAIC Group
- [ ] Received For Public Comment
- [X] Adopted Date: 03/16/2021
- [ ] Rejected Date
- [ ] Deferred Date
- [ ] Other (Specify)

### BLANK(S) TO WHICH PROPOSAL APPLIES

- [X] ANNUAL STATEMENT
- [X] QUARTERLY STATEMENT
- [X] Life, Accident & Health/Fraternal
- [X] Property/Casualty
- [X] Health
- [X] Separate Accounts
- [X] Protected Cell
- [X] Health (Life Supplement)

### IDENTIFICATION OF ITEM(S) TO CHANGE

Expand the number of characters used from seven to ten in the investment line categories for Schedules D, DA, DL and E excluding Schedule D, Part 6 (Sections 1 and 2) and Schedule E (Part 1 and 3). Add line categories for Unaffiliated Certificates of Deposit and Exchange Traded Funds. Split the line categories for Mutual Funds, Investment Unit Trusts and Closed-End Funds into lines indicating if the fund has been assigned a designation by the SVO or not. Make changed to Summary Investment Schedule, Summary by Country and Schedule D, Part 1A (Sections 1 and 2) to reflect the additional line categories.

### REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of the proposal is to change the line number size to accommodate more line categories and to allow for room in the numbering scheme for Schedules D, DA, DL and E to add additional lines in the future without major disruption of line numbering. It also adds new lines to address crosscheck issues and reporting questions that have been received in the past.

### NAIC STAFF COMMENTS

Comment on Effective Reporting Date: __________________________

Other Comments: ____________________________________________

---

** This section must be completed on all forms.

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### SCHEDULE D – Part 1

#### Long-Term Bonds Owned December 31 of Current Year

**Category** | **Line Number**
--- | ---
Bonds: | 
U.S. Governments |  
Issuer Obligations | 001999999
Residential Mortgage-Backed Securities | 002999999
Commercial Mortgage-Backed Securities | 003999999
Other Loan-Backed and Structured Securities | 004999999
Subtotals – U.S. Governments | 059999901

All Other Governments |  
Issuer Obligations | 069999902
Residential Mortgage-Backed Securities | 079999902
Commercial Mortgage-Backed Securities | 089999902
Other Loan-Backed and Structured Securities | 099999902
Subtotals – All Other Governments | 109999903

U.S. States, Territories and Possessions (Direct and Guaranteed) |  
Issuer Obligations | 119999904
Residential Mortgage-Backed Securities | 129999904
Commercial Mortgage-Backed Securities | 139999904
Other Loan-Backed and Structured Securities | 149999904
Subtotals – U.S. States, Territories and Possessions (Direct and Guaranteed) | 179999905

U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) |  
Issuer Obligations | 159999906
Residential Mortgage-Backed Securities | 169999906
Commercial Mortgage-Backed Securities | 179999906
Other Loan-Backed and Structured Securities | 189999906
Subtotals – U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) | 219999907

U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions |  
Issuer Obligations | 259999908
Residential Mortgage-Backed Securities | 269999908
Commercial Mortgage-Backed Securities | 279999908
Other Loan-Backed and Structured Securities | 289999908
Subtotals – U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions | 319999909

Industrial and Miscellaneous (Unaffiliated) |  
Issuer Obligations | 329999910
Residential Mortgage-Backed Securities | 339999910
Commercial Mortgage-Backed Securities | 349999910
Other Loan-Backed and Structured Securities | 359999910
Subtotals – Industrial and Miscellaneous (Unaffiliated) | 389999911
Hybrid Securities

<table>
<thead>
<tr>
<th>Issuer Obligations</th>
<th>Residential Mortgage-Backed Securities</th>
<th>Commercial Mortgage-Backed Securities</th>
<th>Other Loan-Backed and Structured Securities</th>
<th>Subtotals – Hybrid Securities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td>4299999</td>
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<td>4599999</td>
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</tbody>
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Parent, Subsidiaries and Affiliates

<table>
<thead>
<tr>
<th>Issuer Obligations</th>
<th>Residential Mortgage-Backed Securities</th>
<th>Commercial Mortgage-Backed Securities</th>
<th>Other Loan-Backed and Structured Securities</th>
<th>Affiliated Bank Loans – Issued</th>
<th>Affiliated Bank Loans – Acquired</th>
<th>Subtotals – Parent, Subsidiaries and Affiliates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4999999</td>
<td>41999999</td>
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</table>

SVO Identified Funds

<table>
<thead>
<tr>
<th>Exchange Traded Funds – as Identified by the SVO</th>
<th>Bond Mutual Funds – as Identified by the SVO</th>
<th>Subtotals – SVO Identified Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>5899999</td>
</tr>
</tbody>
</table>

Unaffiliated Bank Loans

<table>
<thead>
<tr>
<th>Unaffiliated Bank Loans – Issued</th>
<th>Unaffiliated Bank Loans – Acquired</th>
<th>Subtotals – Unaffiliated Bank Loans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6399999</td>
<td>81999999</td>
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</tbody>
</table>

Unaffiliated Certificates of Deposit

<table>
<thead>
<tr>
<th>Subtotals – Unaffiliated Certificates of Deposit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Total Bonds

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
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</tr>
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</table>

**Detail Eliminated to Conserve Space**

<table>
<thead>
<tr>
<th>Column 3</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enter “*” in this column for all SVO Identified Funds designated for systematic value.</td>
</tr>
<tr>
<td></td>
<td>Enter “@” in this column for all Principal STRIP Bonds or other zero-coupon bonds.</td>
</tr>
<tr>
<td></td>
<td>Enter “$” in this column for Certificates of Deposit under the FDIC limit.</td>
</tr>
<tr>
<td></td>
<td>Enter “&amp;” in this column for TBA (To Be Announced) securities.</td>
</tr>
<tr>
<td></td>
<td>Enter “^” in this column for all assets that are bifurcated between the insulated separate account filing and the non-insulated separate account filing.</td>
</tr>
</tbody>
</table>

If bonds are not under the exclusive control of the company as shown in the General Interrogatories, they are to be identified by placing one of the codes **identified in the Investment Schedules General Instructions** in this column.
If the security is an SVO Identified Fund designated for systematic value, Principal STRIP bond or other zero coupon bond, Certificates of Deposit under the FDIC limit or a TBA (To Be Announced) security and is not under the exclusive control of the company, the “*”, “@”, “$” or “&” should appear first, immediately followed by the appropriate code (identified in the Investment Schedules General Instructions).

Separate Account Filing Only:

If the asset is a bifurcated asset between the insulated separate account filing and the non-insulated separate account filing, the “^” should appear first and may be used simultaneously with the “*”, “@”, “$” or “&” with the “^” preceding the other characters (“*”, “@”, “$” or “&”) depending on the asset being reported, immediately followed by the appropriate code (identified in the Investment Schedules General Instructions).

Column 26 – Collateral Type

Use only for securities included in the following subtotal lines.

Industrial and Miscellaneous (Unaffiliated)

- Residential Mortgage-Backed/Securities ......................................................... 33999991029999999
- Commercial Mortgage-Backed Securities ........................................................ 34999991039999999
- Other Loan-Backed and Structured Securities .................................................. 35999991049999999

Enter one of the following codes to indicate collateral type. Pick exactly one collateral type for each reported security. For securities that fit in more than one type, pick the predominant one. Judgment may need to be used when making selections involving prime, Alt-A and subprime, as there are no uniform definitions for these collateral types. In the description field, use abbreviations like ABS, CDO or CLO to disclose the type of the loan-backed/structured security.

Note: Various investments below require SVO review and approval, please refer to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) for further description.

1 Residential Mortgage Loans/RMBS

Include all types of residential first lien mortgage loans as collateral (e.g., prime, subprime, Alt-A).

2 Commercial Mortgage Loans/CMBS

Include all types of commercial mortgage loans as collateral (e.g., conduits, single name, etc.).

3 Home Equity

Include all home equity loans and/or home equity lines of credit as collateral. These are not first liens and are deemed loans to individuals. Bonds that are collateralized by home equity loans/lines of credit are considered asset-backed securities (ABS) rather than RMBS.

4 Individual Obligations – Credit Card, Auto, Student Loans and Recreational Vehicles

Include bonds collateralized by individual obligations. Do not include individual obligations that have a real-estate aspect.

5 Corporate/Industrial Obligations – Tax Receivables, Utility Receivables, Trade Receivables, Small Business Loans, Commercial Paper
Include bonds collateralized by corporate or industrial obligations (sometimes referred to as commercial obligations).

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Lease Transactions – Aircraft Leases, Equipment Leases and Equipment Trust Certificates</td>
</tr>
<tr>
<td></td>
<td>Include bonds collateralized by leases. Equipment leases are loans on heavy equipment. Equipment trust certificates are certificates that entitle the holder to the lease payments on the underlying assets.</td>
</tr>
<tr>
<td>7</td>
<td>CLO/CBO/CDO</td>
</tr>
<tr>
<td></td>
<td>Include bank loans, which securitize CLOs; investment grade and high-yield corporate bonds, which securitize CBOs; and corporate bonds and structured securities, which securitize CDOs.</td>
</tr>
<tr>
<td>8</td>
<td>Manufactured Housing and Mobile Home Loans</td>
</tr>
<tr>
<td></td>
<td>Include manufactured housing loans and mobile home loans as collateral. These are not typical residential mortgage loans, and when they securitize bonds, they are considered ABS.</td>
</tr>
<tr>
<td>9</td>
<td>Credit Tenant Loans</td>
</tr>
<tr>
<td></td>
<td>Real estate loans secured by the obligation of a single (usually investment grade) company to pay debt service by means of rental payments under a lease, where real estate is pledged as collateral also referred to as credit tenant lease, sale-leaseback or CTL.</td>
</tr>
<tr>
<td>10</td>
<td>Ground Lease Financing</td>
</tr>
<tr>
<td></td>
<td>Real estate loans secured by the obligation to pay debt service by means of rental payments of subleased property; where a long-term ground lease was issued in which the lessee intends significant land development and the subleasing of such property to other long-term tenants.</td>
</tr>
<tr>
<td>11</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>Include other collateral types that do not fit into categories 1 through 9.</td>
</tr>
</tbody>
</table>

**Detail Eliminated to Conserve Space**

**NAIC Designation Category Footnote:**

Provide the total book/adjusted carrying value amount by NAIC Designation Category that represents the amount reported in Column 11.

The sum of the amounts reported for each NAIC Designation Category in the footnote should equal Line 83999992509999999.

**Detail Eliminated to Conserve Space**
**SCHEDULE D – PART 2 – SECTION 1**

**PREFERRED STOCKS OWNED DECEMBER 31 OF CURRENT YEAR**

<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
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</thead>
<tbody>
<tr>
<td><strong>Industrial and Miscellaneous (Unaffiliated):</strong></td>
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</tr>
<tr>
<td>Perpetual Preferred</td>
<td>4019999999</td>
</tr>
<tr>
<td>Redeemable Preferred</td>
<td>4029999999</td>
</tr>
<tr>
<td>Subtotals – Industrial and Miscellaneous (Unaffiliated)</td>
<td>4109999999</td>
</tr>
<tr>
<td><strong>Parent, Subsidiaries and Affiliates:</strong></td>
<td></td>
</tr>
<tr>
<td>Perpetual Preferred</td>
<td>4319999999</td>
</tr>
<tr>
<td>Redeemable Preferred</td>
<td>4329999999</td>
</tr>
<tr>
<td>Subtotals – Parent, Subsidiaries and Affiliates</td>
<td>4409999999</td>
</tr>
<tr>
<td><strong>Total Preferred Stocks</strong></td>
<td>4509999999</td>
</tr>
<tr>
<td><strong>Industrial and Miscellaneous (Unaffiliated) Perpetual Preferred</strong></td>
<td>8499999</td>
</tr>
<tr>
<td><strong>Industrial and Miscellaneous (Unaffiliated) Redeemable Preferred</strong></td>
<td>8599999</td>
</tr>
<tr>
<td><strong>Parent, Subsidiaries and Affiliates Perpetual Preferred</strong></td>
<td>8699999</td>
</tr>
<tr>
<td><strong>Parent, Subsidiaries and Affiliates Redeemable Preferred</strong></td>
<td>8799999</td>
</tr>
<tr>
<td><strong>Total Preferred Stocks</strong></td>
<td>8999999</td>
</tr>
</tbody>
</table>

### Detail Eliminated to Conserve Space

**Column 20 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol**

Provide the appropriate combination of NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol for each security. The list of valid Administrative Symbols is shown below.

The listing of valid NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol combinations can be found on the NAIC’s website for the Securities Valuation Office ([www.naic.org/svo.htm](http://www.naic.org/svo.htm)).

Exchange Traded Funds should be reported as perpetual securities.

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol will be shown as one column on the printed schedule but will be three sub-columns in the data table.

- NAIC Designation Column 20A
- NAIC Designation Modifier Column 20B
- SVO Administrative Symbol Column 20C

On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).
Designation Modifier:

The NAIC Designation Modifier should only be used for securities reported on lines below if eligible to receive one, as defined in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual), otherwise, the field should be left blank.

- Industrial and Miscellaneous (Unaffiliated) Perpetual Preferred Line 84999994019999999
- Industrial and Miscellaneous (Unaffiliated) Redeemable Preferred Line 85999994029999999

The NAIC Designation Modifier should be left blank for securities reported on lines below.

- Parent, Subsidiaries and Affiliates Line 86999994319999999
- Parent, Subsidiaries and Affiliates Line 87999994329999999

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments reporting an NAIC Designation 6, therefore, the NAIC Designation Modifier field should be left blank.

Refer to the P&P Manual for the application of these modifiers.

Following are valid administrative symbols for preferred stock. Refer to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* for the application of these symbols.

- **S** Additional or other non-payment risk assigned by the SVO or SSG
- **SYE** Additional or other non-payment risk - Year-end carry over
- **FE** Filing Exempt assigned by the SVO
- **YE** Year-end carry over assigned by the SVO
- **IF** Initial filing - insurer reported designation with Admin Symbol assigned by the SVO
- **PL** Private Letter Rating assigned by the SVO
- **PLGI** Private Letter Rating – insurer assigned and reported on General Interrogatory
- **RT** Regulatory Transaction
- **RTS** Regulatory Transaction - SVO Reviewed
- **RTIF** Regulatory Transaction - Initial Filing Submitted to SVO
- **RTSYE** Regulatory Transaction - SVO Reviewed - Year-end carry over
- **GI** Insurer assigned and reported on General Interrogatory
- **F** Sub-paragraph D Company – insurer self-designated
- **Z** Insurer assigned and reported subject to limitation
- **Z** Limited to NAIC Designation 6 – insurer assigned
- **Z*** Regulatory review initiated by either the SVO Director, Financial Condition (E) Committee, Executive (EX) Committee or VOSTF.
- **ND*** Regulatory review for an assessment of regulatory policy for the investment or regulatory reporting instructions to implement applicable policy.
The NAIC Designation Category is the combination of NAIC Designation and NAIC Designation Modifier. Valid combinations of NAIC Designation and NAIC Designation Modifier for NAIC Designation Category are shown below:

<table>
<thead>
<tr>
<th>NAIC Designation</th>
<th>NAIC Designation Modifier</th>
<th>NAIC Designation Category</th>
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<td>1</td>
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</table>

Detail Eliminated to Conserve Space

NAIC Designation Category Footnote:

Provide the total book/adjusted carrying value amount by NAIC Designation Category that represents the amount reported in Column 8.

The sum of the amounts reported for each NAIC Designation Category in the footnote should equal the sum of Lines 84999999, 4019999999, and 859999940299999.
## Schedule D – Part 2 – Section 2

**Common Stocks Owned December 31 of Current Year**

<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
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<td>Publicly Traded</td>
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<td>Other</td>
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<td>Subtotals – Industrial and Miscellaneous (Unaffiliated)</td>
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<tr>
<td><strong>Mutual Funds</strong></td>
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<tr>
<td>Designation Assigned by SVO</td>
<td>5319999999</td>
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<tr>
<td>Designation Not Assigned by SVO</td>
<td>5329999999</td>
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<td>Subtotals – Mutual Funds</td>
<td>5409999999</td>
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<tr>
<td><strong>Unit Investment Trusts</strong></td>
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</tr>
<tr>
<td>Designation Assigned by SVO</td>
<td>5519999999</td>
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<tr>
<td>Designation Not Assigned by SVO</td>
<td>5529999999</td>
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<tr>
<td>Subtotals – Unit Investment Trusts</td>
<td>5609999999</td>
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<td><strong>Closed-End Funds</strong></td>
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</tr>
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<td>Designation Assigned by SVO</td>
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<tr>
<td>Designation Not Assigned by SVO</td>
<td>5729999999</td>
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<tr>
<td>Subtotals – Closed-End Funds</td>
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</tr>
<tr>
<td><strong>Exchange Traded Funds</strong></td>
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<tr>
<td>Designation Assigned by SVO</td>
<td>5819999999</td>
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<tr>
<td><strong>Parent, Subsidiaries and Affiliates:</strong></td>
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<tr>
<td>Publicly Traded</td>
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<tr>
<td>Other</td>
<td>5929999999</td>
</tr>
<tr>
<td>Subtotals – Parent, Subsidiaries and Affiliates</td>
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</tr>
<tr>
<td><strong>Total Common Stocks</strong></td>
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<tr>
<td><strong>Total Preferred and Common Stocks</strong></td>
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<tr>
<td><strong>Industrial and Miscellaneous (Unaffiliated) Publicly Traded</strong></td>
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<td><strong>Industrial and Miscellaneous (Unaffiliated) Other</strong></td>
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<td><strong>Parent, Subsidiaries and Affiliates Publicly Traded</strong></td>
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<td><strong>Parent, Subsidiaries and Affiliates Other</strong></td>
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<td><strong>Unit Investment Trusts</strong></td>
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<td><strong>Closed-End Funds</strong></td>
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<tr>
<td><strong>Total Common Stocks</strong></td>
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<tr>
<td><strong>Total Preferred and Common Stocks</strong></td>
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</tbody>
</table>

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Column 18 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

For securities reported on Line 9499999 5319999999 (Mutual Funds), Line 9599999 5519999999 (Unit Investment Trusts) and Line 9699999 5719999999 (Closed-End Funds), provide the appropriate NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol combination as assigned by the Securities Valuation Office and published in AVS+ per the instructions in the Purposes and Procedures Manual of the NAIC Investment Analysis Office on the Compilation and Publication of the SVO List of Investment Securities. A list of these funds can be found on the Securities Valuation Office Web page (https://www.naic.org/svo.htm).

NAIC Designation and NAIC Designation Modifier should not be provided for securities reported on these line categories stated above that have not been assigned one by the Securities Valuation Office. For all other common stock line categories, the NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol should not be provided.

The listing of valid NAIC Designations, NAIC Designation Modifier and SVO Administrative Symbol combinations can be found on the NAIC’s website for the Securities Valuation Office (www.naic.org/svo.htm).

The NAIC Designation, Designation Modifier and SVO Administrative Symbol will be shown as one column on the printed schedule but will be three sub-columns in the data table.

- NAIC Designation Column 18A
- NAIC Designation Modifier Column 18B
- SVO Administrative Symbol Column 18C

On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).

NAIC Designation Modifier:

The NAIC Designation Modifier should only be used for securities reported on Line 9499999 5319999999 (Mutual Funds Designation Assigned by SVO), Line 9599999 5519999999 (Unit Investment Trusts Designation Assigned by SVO) and Line 9699999 5719999999 (Closed-End Funds Designation Assigned by SVO) if eligible to receive one, as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), otherwise, should not be provided.

The Designation Modifier should not be provided for securities reported on lines below.

- Industrial and Miscellaneous (Unaffiliated) Publicly Traded Line 9099999 5019999999
- Industrial and Miscellaneous (Unaffiliated) Other Line 9199999 5029999999
- Mutual Funds Designation Not Assigned by SVO Line 5329999999
- Unit Investment Trusts Designation Not Assigned by SVO Line 5529999999
- Closed-End Funds Designation Not Assigned by SVO Line 5729999999
- Exchange Traded Funds Line 5819999999
- Parent, Subsidiaries and Affiliates Publicly Traded
  Line 92999995919999999
- Parent, Subsidiaries and Affiliates Other
  Line 93999995929999999

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments reporting an NAIC Designation 6, therefore, the NAIC Designation Modifier should not be provided.

Refer to the P&P Manual for the application of these modifiers.

**SVO Administrative Symbol:**

Following are valid SVO Administrative Symbols for common stock. Refer to the P&P Manual for the application of these symbols.

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<tr>
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<th>Year-end carry over</th>
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<td>Regulatory review initiated by either the SVO Director, Financial Condition (E) Committee, Executive (EX) Committee or VOSTF.</td>
</tr>
<tr>
<td>ND*</td>
<td>Regulatory review for an assessment of regulatory policy for the investment or regulatory reporting instructions to implement applicable policy.</td>
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The NAIC Designation Category is the combination of NAIC Designation and NAIC Designation Modifier. Valid combinations of NAIC Designation and NAIC Designation Modifier for NAIC Designation Category are shown below:

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<th>NAIC Designation Modifier</th>
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</tbody>
</table>

**Detail Eliminated to Conserve Space**

NAIC Designation Category Footnote:
Provide the total book/adjusted carrying value amount by NAIC Designation Category that represents the amount reported in Column 6.
## SCHEDULE D – PART 3

### LONG-TERM BONDS AND STOCKS ACQUIRED DURING CURRENT YEAR

**Detail Eliminated to Conserve Space**

<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
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<td><strong>Bonds:</strong></td>
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<td>U.S. Governments</td>
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<tr>
<td>All Other Governments</td>
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<td>U.S. Political Subdivisions of States, Territories and Possessions</td>
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<td>Parent, Subsidiaries and Affiliates</td>
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<td><strong>Subtotals – Bonds – Part 3</strong></td>
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<td><strong>Summary item from Part 5 for Bonds</strong></td>
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<td><strong>Subtotals – Bonds</strong></td>
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<td><strong>Preferred Stocks:</strong></td>
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<td><strong>Industrial and Miscellaneous (Unaffiliated)</strong></td>
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<td>Parent, Subsidiaries and Affiliates Redeemable Preferred</td>
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<td><strong>Closed-End Funds</strong></td>
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<td><strong>Parent, Subsidiaries and Affiliates</strong></td>
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### SCHEDULE D – PART 4

**LONG-TERM BONDS AND STOCKS SOLD, REDEEMED OR OTHERWISE DISPOSED OF DURING CURRENT YEAR**

**Detail Eliminated to Conserve Space**

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<td>Parent, Subsidiaries and Affiliates</td>
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<td><strong>Summary item from Part 5 for Bonds</strong></td>
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<td><strong>Subtotals – Bonds</strong></td>
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<td>Parent, Subsidiaries and Affiliates Redeemable Preferred</td>
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<td><strong>Subtotals – Preferred Stocks – Part 3</strong></td>
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<td><strong>Summary item from Part 5 for Preferred Stocks</strong></td>
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<tr>
<td><strong>Subtotals – Preferred Stocks</strong></td>
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<td><strong>Common Stocks:</strong></td>
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</table>

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## SCHEDULE D – PART 5

**LONG-TERM BONDS AND STOCKS ACQUIRED DURING THE YEAR AND FULLY DISPOSED OF DURING CURRENT YEAR**

---

**Detail Eliminated to Conserve Space**

### Category | Line Number
--- | ---
**Bonds:**
U.S. Governments | 05999990109999999
All Other Governments | 10999990309999999
U.S. States, Territories and Possessions (Direct and Guaranteed) | 17099990509999999
U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) | 24099990709999999
U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions | 31999990909999999
Industrial and Miscellaneous (Unaffiliated) | 34999991109999999
Hybrid Securities | 48999991309999999
Parent, Subsidiaries and Affiliates | 55999991509999999
SVO Identified Funds | 80999990161999999
Unaffiliated Bank Loans | 82999990909999999
Unaffiliated Certificates of Deposit | 2019999999
Subtotals – Bonds – Part 3 | 83999990250999999
Summary item from Part 5 for Bonds: ................................................................. 83999982509999999
Subtotals – Bonds ............................................................................................ 83999992509999999

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<tr>
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<td></td>
</tr>
<tr>
<td>Designations Assigned by the SVO</td>
<td>5319999999</td>
</tr>
<tr>
<td>Designations Not Assigned by the SVO</td>
<td>5329999999</td>
</tr>
<tr>
<td>Unit Investment Trusts</td>
<td></td>
</tr>
<tr>
<td>Designations Assigned by the SVO</td>
<td>5519999999</td>
</tr>
<tr>
<td>Designations Not Assigned by the SVO</td>
<td>5529999999</td>
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<tr>
<td>Closed-End Funds</td>
<td></td>
</tr>
<tr>
<td>Designations Assigned by the SVO</td>
<td>5719999999</td>
</tr>
<tr>
<td>Designations Not Assigned by the SVO</td>
<td>5729999999</td>
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<tr>
<td>Exchange Traded Funds</td>
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</tr>
<tr>
<td>Parent, Subsidiaries and Affiliates</td>
<td></td>
</tr>
<tr>
<td>Parent, Subsidiaries and Affiliates Publicly Traded</td>
<td>92999995919999999</td>
</tr>
<tr>
<td>Parent, Subsidiaries and Affiliates Other</td>
<td>93999995929999999</td>
</tr>
<tr>
<td>Mutual Funds</td>
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</tr>
<tr>
<td>Unit Investment Trusts</td>
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<tr>
<td>Closed End Funds</td>
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<tr>
<td>Subtotals – Common Stocks</td>
<td>97999995989999999</td>
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<tr>
<td>Subtotals – Preferred and Common Stocks</td>
<td>98999995999999999</td>
</tr>
<tr>
<td>Totals</td>
<td>99999996009999999</td>
</tr>
</tbody>
</table>
SCHEDULE D – PART 6 – SECTION 1

VALUATION OF SHARES OF SUBSIDIARY, CONTROLLED OR AFFILIATED COMPANIES

If a reporting entity has any common stock or preferred stock reported for any of the following required categories or subcategories, it shall report the subtotal amount of the corresponding category or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Stocks:</td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>0199999</td>
</tr>
<tr>
<td>U.S. Property &amp; Casualty Insurer</td>
<td>0299999</td>
</tr>
<tr>
<td>U.S. Life Insurer</td>
<td>0399999</td>
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<tr>
<td>U.S. Health Entity #</td>
<td>0499999</td>
</tr>
<tr>
<td>Alien Insurer</td>
<td>0599999</td>
</tr>
<tr>
<td>Non-Insurer Which Controls Insurer</td>
<td>0699999</td>
</tr>
<tr>
<td>*Investment Subsidiary</td>
<td>0799999</td>
</tr>
<tr>
<td>Other Affiliates</td>
<td>0899999</td>
</tr>
<tr>
<td>Subtotals – Preferred Stocks</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Stocks:</td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>1099999</td>
</tr>
<tr>
<td>U.S. Property &amp; Casualty Insurer</td>
<td>1199999</td>
</tr>
<tr>
<td>U.S. Life Insurer</td>
<td>1299999</td>
</tr>
<tr>
<td>U.S. Health Entity #</td>
<td>1399999</td>
</tr>
<tr>
<td>Alien Insurer</td>
<td>1499999</td>
</tr>
<tr>
<td>Non-Insurer Which Controls Insurer</td>
<td>1599999</td>
</tr>
<tr>
<td>*Investment Subsidiary</td>
<td>1699999</td>
</tr>
<tr>
<td>Other Affiliates</td>
<td>1799999</td>
</tr>
<tr>
<td>Subtotals – Common Stocks</td>
<td>1899999</td>
</tr>
</tbody>
</table>

Totals – Preferred and Common Stocks ......................................................... 1999999
If a reporting entity has any common or preferred stocks reported for any of the following required categories or subcategories, it shall report the subtotal amount of the corresponding category or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Stocks</td>
<td>0199999</td>
</tr>
<tr>
<td>Common Stocks</td>
<td>0299999</td>
</tr>
<tr>
<td>Totals – Preferred and Common Stocks</td>
<td>0399999</td>
</tr>
</tbody>
</table>
## SCHEDULE DA – PART 1

### SHORT-TERM INVESTMENTS OWNED DECEMBER 31 OF CURRENT YEAR

<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bonds:</strong></td>
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</tr>
<tr>
<td>U.S. Governments</td>
<td></td>
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<tr>
<td>Issuer Obligations</td>
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<td>Residential Mortgage-Backed Securities</td>
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<td>Commercial Mortgage-Backed Securities</td>
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<tr>
<td>Other Loan-Backed and Structured Securities</td>
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<tr>
<td>Subtotals – U.S. Governments</td>
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<tr>
<td>All Other Governments</td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
<td>06999990219999999</td>
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<tr>
<td>Residential Mortgage-Backed Securities</td>
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<td>Commercial Mortgage-Backed Securities</td>
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</tr>
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<td>Other Loan-Backed and Structured Securities</td>
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<tr>
<td>Subtotals – All Other Governments</td>
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</tr>
<tr>
<td>U.S. States, Territories and Possessions (Direct and Guaranteed)</td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
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<tr>
<td>Residential Mortgage-Backed Securities</td>
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<td>Commercial Mortgage-Backed Securities</td>
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<td>Other Loan-Backed and Structured Securities</td>
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<tr>
<td>Subtotals – U.S. States, Territories and Possessions (Direct and Guaranteed)</td>
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<td>U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed)</td>
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</tr>
<tr>
<td>Issuer Obligations</td>
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<tr>
<td>Residential Mortgage-Backed Securities</td>
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<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>17999990639999999</td>
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<tr>
<td>Other Loan-Backed and Structured Securities</td>
<td>18999990649999999</td>
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<tr>
<td>Subtotals – U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed)</td>
<td>24999990709999999</td>
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<tr>
<td>U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions</td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
<td>25999990819999999</td>
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<tr>
<td>Residential Mortgage-Backed Securities</td>
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<td>Commercial Mortgage-Backed Securities</td>
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<tr>
<td>Subtotals – U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions</td>
<td>31999990909999999</td>
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<tr>
<td>Industrial and Miscellaneous (Unaffiliated)</td>
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<tr>
<td>Issuer Obligations</td>
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<td>Residential Mortgage-Backed Securities</td>
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<td>Commercial Mortgage-Backed Securities</td>
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<tr>
<td>Other Loan-Backed and Structured Securities</td>
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<td>Subtotals – Industrial and Miscellaneous (Unaffiliated)</td>
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<td>Hybrid Securities</td>
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<td>Issuer Obligations</td>
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</table>

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18
<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
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<tbody>
<tr>
<td>Residential Mortgage-Backed Securities</td>
<td>43,999,999</td>
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<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>44,999,999</td>
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<tr>
<td>Other Loan-Backed and Structured Securities</td>
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<tr>
<td>Subtotals – Hybrid Securities</td>
<td>48,999,999</td>
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<tr>
<td>Parent, Subsidiaries and Affiliates Bonds</td>
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<tr>
<td>Issuer Obligations</td>
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<td>Residential Mortgage-Backed Securities</td>
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<td>Commercial Mortgage-Backed Securities</td>
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<tr>
<td>Other Loan-Backed and Structured Securities</td>
<td>52,999,999</td>
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<tr>
<td>Affiliated Bank Loans – Issued</td>
<td>53,999,999</td>
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<tr>
<td>Affiliated Bank Loans – Acquired</td>
<td>54,999,999</td>
</tr>
<tr>
<td>Subtotals – Parent, Subsidiaries and Affiliates Bonds</td>
<td>55,999,999</td>
</tr>
<tr>
<td>SVO Identified Funds</td>
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<tr>
<td>Exchange Traded Funds – as Identified by the SVO</td>
<td>58,999,999</td>
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<tr>
<td>Bond Mutual Funds – as Identified by the SVO</td>
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<td>Subtotals – SVO Identified Funds</td>
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<tr>
<td>Unaffiliated Bank Loans</td>
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<tr>
<td>Unaffiliated Bank Loans – Issued</td>
<td>63,999,999</td>
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<tr>
<td>Unaffiliated Bank Loans – Acquired</td>
<td>64,999,999</td>
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<tr>
<td>Subtotals – Unaffiliated Bank Loans</td>
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<tr>
<td>Unaffiliated Certificates of Deposit</td>
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<tr>
<td>Total Bonds</td>
<td></td>
</tr>
<tr>
<td>Subtotals – Issuer Obligations</td>
<td>76,999,999</td>
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<tr>
<td>Subtotals – Residential Mortgage-Backed Securities</td>
<td>77,999,999</td>
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<td>Subtotals – Commercial Mortgage-Backed Securities</td>
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<tr>
<td>Subtotals – Other Loan-Backed and Structured Securities</td>
<td>79,999,999</td>
</tr>
<tr>
<td>Subtotals – SVO Identified Funds</td>
<td>80,999,999</td>
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<tr>
<td>Subtotals – Affiliated Bank Loans</td>
<td>81,999,999</td>
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<td>Subtotals – Unaffiliated Bank Loans</td>
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<tr>
<td>Subtotals – Unaffiliated Certificates of Deposit</td>
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<td>Subtotals – Bonds</td>
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<tr>
<td>Parent, Subsidiaries and Affiliates</td>
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<tr>
<td>Mortgage Loans</td>
<td>84,999,999</td>
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<tr>
<td>Other Short-Term Invested Assets</td>
<td>85,999,999</td>
</tr>
<tr>
<td>Subtotals – Parent, Subsidiaries and Affiliates</td>
<td>86,999,999</td>
</tr>
<tr>
<td>Mortgage Loans</td>
<td>87,999,999</td>
</tr>
<tr>
<td>Other Short-Term Invested Assets</td>
<td>90,999,999</td>
</tr>
<tr>
<td>Total Short-Term Investments</td>
<td>91,999,999</td>
</tr>
</tbody>
</table>
Column 22 – NAIC Designation Category

Provide the appropriate combination of NAIC Designation Equivalent (1 through 6) and NAIC Designation Modifier Equivalent (A through G) (see table below) for each security shown.

The NAIC Designation and NAIC Designation Modifier Equivalent should not be provided for the following lines:

- Parent, Subsidiaries and Affiliates – Mortgage Loans Line 84999997019999999
- Parent, Subsidiaries and Affiliates – Other Short-Term Invested Assets Line 85999997029999999
- Mortgage Loans Line 87999997309999999
- Other Short-Term Invested Assets Line 90999997509999999

Exchange Traded Funds – as Identified by the SVO should be reported as perpetual securities.

The NAIC Designation Category will be two sub-columns in the data table.

- NAIC Designation Equivalent Column 22A
- NAIC Designation Modifier Equivalent Column 22B

NAIC Designation Equivalent:

For the NAIC Designation Equivalent, use the NAIC designation that would have been used for the investment had it been reported on Schedule D, Part 1 if available. If no NAIC Designation is available, the reporting entity should use a NAIC Designation Equivalent most closely resembles their credit risk the investment.

NAIC Designation Modifier Equivalent:

Bonds (Lines 01999990019999999 through 65999920199999999)

Use the NAIC Designation Modifier that would have been used for the investment had it been reported on Schedule D, Part 1 if available.

If no NAIC Designation Modifier is available, the reporting entity should use a NAIC Designation Modifier Equivalent most closely resembles their credit risk the investment.

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments reporting an NAIC Designation 6, therefore, the NAIC Designation Modifier field should be left blank.

Refer to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* for the application of these codes.
The NAIC Designation Category Equivalent is the combination of NAIC Designation Equivalent and NAIC Designation Modifier Equivalent. Valid combinations of NAIC Designation Equivalent and NAIC Designation Modifier Equivalent for NAIC Designation Category Equivalent are shown below:

<table>
<thead>
<tr>
<th>NAIC Designation Equivalent</th>
<th>NAIC Designation Modifier Equivalent</th>
<th>NAIC Designation Category Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 A</td>
<td>1A</td>
<td>1A</td>
</tr>
<tr>
<td>1 B</td>
<td>1B</td>
<td>1B</td>
</tr>
<tr>
<td>1 C</td>
<td>1C</td>
<td>1C</td>
</tr>
<tr>
<td>1 D</td>
<td>1D</td>
<td>1D</td>
</tr>
<tr>
<td>1 E</td>
<td>1E</td>
<td>1E</td>
</tr>
<tr>
<td>1 F</td>
<td>1F</td>
<td>1F</td>
</tr>
<tr>
<td>1 G</td>
<td>1G</td>
<td>1G</td>
</tr>
<tr>
<td>2 A</td>
<td>2A</td>
<td>2A</td>
</tr>
<tr>
<td>2 B</td>
<td>2B</td>
<td>2B</td>
</tr>
<tr>
<td>2 C</td>
<td>2C</td>
<td>2C</td>
</tr>
<tr>
<td>3 A</td>
<td>3A</td>
<td>3A</td>
</tr>
<tr>
<td>3 B</td>
<td>3B</td>
<td>3B</td>
</tr>
<tr>
<td>3 C</td>
<td>3C</td>
<td>3C</td>
</tr>
<tr>
<td>4 A</td>
<td>4A</td>
<td>4A</td>
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<tr>
<td>4 B</td>
<td>4B</td>
<td>4B</td>
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<tr>
<td>4 C</td>
<td>4C</td>
<td>4C</td>
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<tr>
<td>5 A</td>
<td>5A</td>
<td>5A</td>
</tr>
<tr>
<td>5 B</td>
<td>5B</td>
<td>5B</td>
</tr>
<tr>
<td>5 C</td>
<td>5C</td>
<td>5C</td>
</tr>
</tbody>
</table>

NAIC Designation Category Equivalent Footnote:

Provide the total book/adjusted carrying value amount by NAIC Designation Category Equivalent that represents the amount reported in Column 7.

The sum of the amounts reported for each NAIC Designation Category Equivalent in the footnote should equal Line 83999999999999999999.
## SCHEDULE DL – PART 1

**SEcurities Lending COLLateral ASSETS**

Reinvested Collateral Assets Owned December 31 Current Year

(Securities lending collateral assets reported in aggregate on Line 10 of the asset page and not included on Schedules A, B, BA, D, DB and E.)

---

<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bonds (Schedule D, Part 1 type):</strong></td>
<td></td>
</tr>
<tr>
<td>U.S. Governments</td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
<td>01999990019999999</td>
</tr>
<tr>
<td>Residential Mortgage-Backed Securities</td>
<td>02999990029999999</td>
</tr>
<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>03999990039999999</td>
</tr>
<tr>
<td>Other Loan-Backed and Structured Securities</td>
<td>04999990049999999</td>
</tr>
<tr>
<td>Subtotals – U.S. Governments</td>
<td>05999990109999999</td>
</tr>
<tr>
<td>All Other Governments</td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
<td>06999990219999999</td>
</tr>
<tr>
<td>Residential Mortgage-Backed Securities</td>
<td>07999990229999999</td>
</tr>
<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>08999990239999999</td>
</tr>
<tr>
<td>Other Loan-Backed and Structured Securities</td>
<td>09999990249999999</td>
</tr>
<tr>
<td>Subtotals – All Other Governments</td>
<td>10999990309999999</td>
</tr>
<tr>
<td>U.S. States, Territories and Possessions (Direct and Guaranteed)</td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
<td>11999990419999999</td>
</tr>
<tr>
<td>Residential Mortgage-Backed Securities</td>
<td>12999990429999999</td>
</tr>
<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>13999990439999999</td>
</tr>
<tr>
<td>Other Loan-Backed and Structured Securities</td>
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</tr>
<tr>
<td>Subtotals – U.S. States, Territories and Possessions (Direct and Guaranteed)</td>
<td>17999990509999999</td>
</tr>
<tr>
<td>U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed)</td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
<td>18999990619999999</td>
</tr>
<tr>
<td>Residential Mortgage-Backed Securities</td>
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</tr>
<tr>
<td>Commercial Mortgage-Backed Securities</td>
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<tr>
<td>Other Loan-Backed and Structured Securities</td>
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<tr>
<td>Subtotals – U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed)</td>
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</tr>
<tr>
<td>U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions</td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
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</tr>
<tr>
<td>Residential Mortgage-Backed Securities</td>
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</tr>
<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>27999990839999999</td>
</tr>
<tr>
<td>Other Loan-Backed and Structured Securities</td>
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</tr>
<tr>
<td>Subtotals – U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions</td>
<td>31999990909999999</td>
</tr>
<tr>
<td>Industrial and Miscellaneous (Unaffiliated)</td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
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</tr>
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<td>Residential Mortgage-Backed Securities</td>
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<tr>
<td>Commercial Mortgage-Backed Securities</td>
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<tr>
<td>Other Loan-Backed and Structured Securities</td>
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<td>Subtotals – Industrial and Miscellaneous (Unaffiliated)</td>
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Hybrid Securities

<table>
<thead>
<tr>
<th>Issuer Obligations</th>
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<tr>
<td>Residential Mortgage-Backed Securities</td>
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<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>4499999</td>
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<tr>
<td>Other Loan-Backed and Structured Securities</td>
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<tr>
<td>Subtotals – Hybrid Securities</td>
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Parent, Subsidiaries and Affiliates

<table>
<thead>
<tr>
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<tr>
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<td>5099999</td>
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<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>5199999</td>
</tr>
<tr>
<td>Other Loan-Backed and Structured Securities</td>
<td>5299999</td>
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<tr>
<td>Subtotals – Parent, Subsidiaries and Affiliates</td>
<td>5299999</td>
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</table>

SVO Identified Funds

<table>
<thead>
<tr>
<th>Exchange Traded Funds – as Identified by the SVO</th>
<th>5799999</th>
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<tr>
<td>Bond Mutual Funds – as Identified by the SVO</td>
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<td>Subtotals – SVO Identified Funds</td>
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Unaffiliated Bank Loans

<table>
<thead>
<tr>
<th>Unaffiliated Bank Loans – Issued</th>
<th>6099999</th>
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<tr>
<td>Unaffiliated Bank Loans – Acquired</td>
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<td>Subtotals – Unaffiliated Bank Loans</td>
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Unaffiliated Certificates of Deposit

| Subtotals – Unaffiliated Certificates of Deposit       | 20199999 |

Total Bonds

<table>
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<tr>
<th>Subtotals – Issuer Obligations</th>
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<tbody>
<tr>
<td>Subtotals – Residential Mortgage-Backed Securities</td>
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<tr>
<td>Subtotals – Commercial Mortgage-Backed Securities</td>
<td>6599999</td>
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<tr>
<td>Subtotals – Other Loan-Backed and Structured Securities</td>
<td>6699999</td>
</tr>
<tr>
<td>Subtotals – SVO Identified Funds</td>
<td>6799999</td>
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<tr>
<td>Subtotals – Affiliated Bank Loans</td>
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<tr>
<td>Subtotals – Unaffiliated Bank Loans</td>
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<td>Subtotals – Unaffiliated Certificates of Deposit</td>
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<td>Subtotals – Total Bonds</td>
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Stocks:

Preferred Stocks (Schedule D, Part 2, Section 1 type):

**Industrial and Miscellaneous (Unaffiliated)**

<table>
<thead>
<tr>
<th>Perpetual Preferred</th>
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</thead>
<tbody>
<tr>
<td>Redeemable Preferred</td>
<td>40299999</td>
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<td>Subtotals – Industrial and Miscellaneous (Unaffiliated)</td>
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</table>

**Parent, Subsidiaries and Affiliates**

<table>
<thead>
<tr>
<th>Perpetual Preferred</th>
<th>43199999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redeemable Preferred</td>
<td>43299999</td>
</tr>
<tr>
<td>Subtotals – Parent, Subsidiaries and Affiliates</td>
<td>44099999</td>
</tr>
</tbody>
</table>

**Industrial and Miscellaneous (Unaffiliated) Perpetual and Redeemable Preferred**

<table>
<thead>
<tr>
<th>Subtotals – Perpetual and Redeemable Preferred</th>
<th>71899999</th>
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</thead>
<tbody>
<tr>
<td>Subtotals – Parent, Subsidiaries and Affiliates Perpetual and Redeemable Preferred</td>
<td>72999999</td>
</tr>
</tbody>
</table>

**Total Preferred Stocks**

| Subtotals – Parent, Subsidiaries and Affiliates Perpetual and Redeemable Preferred | 73999999 |
## Common Stocks (Schedule D, Part 2, Section 2 type):

### Industrial and Miscellaneous (Unaffiliated):
- Publicly Traded: 501,999,999
- Other: 502,999,999
- Subtotals – Industrial and Miscellaneous (Unaffiliated): 510,999,999

### Mutual Funds
- Designation Assigned by SVO: 531,999,999
- Designation Not Assigned by SVO: 532,999,999
- Subtotals – Mutual Funds: 540,999,999

### Unit Investment Trusts
- Designation Assigned by SVO: 551,999,999
- Designation Not Assigned by SVO: 552,999,999
- Subtotals – Unit Investment Trusts: 560,999,999

### Closed-End Funds
- Designation Assigned by SVO: 571,999,999
- Designation Not Assigned by SVO: 572,999,999
- Subtotals – Closed-End Funds: 580,999,999

### Exchange Traded Funds: 581,999,999

### Parent, Subsidiaries and Affiliates:
- Publicly Traded: 591,999,999
- Other: 592,999,999
- Subtotals – Parent, Subsidiaries and Affiliates: 597,999,999

### Industrial and Miscellaneous (Unaffiliated) : 749,999,999
### Parent, Subsidiaries and Affiliates: 759,999,999
### Mutual Funds: 760,999,999
### Unit Investment Trusts: 779,999,999
### Closed-End Funds: 789,999,999

### Total Common Stocks: 7,999,999,999

### Total Preferred and Common Stocks: 8,099,999,999

### Real Estate (Schedule A type): 8,609,999,999
### Mortgage Loans on Real Estate (Schedule B type): 8,709,999,999
### Other Invested Assets (Schedule BA type): 8,809,999,999
### Short-Term Invested Assets (Schedule DA, Part 1 type): 8,909,999,999
### Cash (Schedule E, Part 1 type): 9,099,999,999
### Cash Equivalents (Schedule E, Part 2 type): 9,199,999,999
### Other Assets: 9,299,999,999

### Totals: 9,999,999,999
Column 1 — CUSIP Identification

CUSIP numbers for all purchased publicly issued securities are available from the broker’s confirmation or the certificate. For private placement securities, the NAIC has created a special number called a PPN to be assigned by the Standard & Poor’s CUSIP Bureau. For foreign securities, use a CINS that is assigned by the Standard & Poor’s CUSIP Bureau: www.cusip.com/cusip/index.htm.

For Lines 0019999999 through 22509999999, if no valid CUSIP, CINS or PPN number exists, then the CUSIP field should be zero-filled and a valid ISIN security number should be reported in (Column 11).

The CUSIP reported for this column should be determined in a manner consistent with the instructions of other schedules for the lines shown below:

Lines 0019999999 through 22509999999 .......... Schedule D, Part 1, Column 1
Lines 24401999999 through 24450999999 .......... Schedule D, Part 2, Section 1, Column 1
Lines 24501999999 through 24598999999 .......... Schedule D, Part 2, Section 2, Column 1
Line 88940999999 ................................................. Schedule BA, Part 1, Column 1
Line 91999999970999999 ..................................... Schedule E, Part 2, Column 1

The CUSIP number should be zero-filled for the following lines:

Real Estate (Schedule A type) ......................................................... 869209999999
Mortgage Loans on Real Estate (Schedule B type) .......................... 879309999999
Short-Term Invested Assets (Schedule DA, Part 1 type) ................ 899509999999
Cash (Schedule E, Part 1 type) .......................................................... 9609999999
Other Assets .................................................................................. 929809999999

--- Detail Eliminated to Conserve Space ---

Column 4 — NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol reported for this column should be determined in a manner consistent with the instructions of other schedules for the lines shown below:

Lines 0019999999 through 22509999999 .... Schedule D, Part 1, Column 6
Lines 24401999999 through 24450999999 24 Schedule D, Part 2, Section 1, Column 20
Lines 24501999999 through 24598999999 20 Schedule D, Part 2, Section 2, Column 17
Line 88940999999 ................................................. Schedule BA, Part 1, Column 7
Line 88950999999 ................................................. Schedule DA, Part 1, Column 22 Line 91999999970999999 ..................................... Schedule E, Part 2, Column 11

For Lines 869209999999, 879309999999, 960999999999 and 929809999999, the column should be left blank.

The NAIC Designation, Designation Modifier and SVO Administrative Symbol will be shown as one column on the printed but will be three sub-columns in the data table.
• NAIC Designation Column 4A
• NAIC Designation Modifier Column 4B
• SVO Administrative Symbol Column 4C

On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).

Column 5 ─ Fair Value

The value reported for this column should be determined in a manner consistent with the fair value column instructions of other schedules for the lines shown below:

Lines 0019999999 through 225099999999 .... Schedule D, Part 1, Column 9
Lines 244019999999 through 244509999999 Schedule D, Part 2, Section 1, Column 10
Lines 244501999999 through 295989999999 Schedule D, Part 2, Section 2, Column 8
Line 889209999999 ...................................... Schedule A, Part 1, Column 10
Line 889309999999 ...................................... FV of the underlying collateral Schedule B, Part 1
Line 889409999999 ...................................... Schedule BA, Part 1, Column 11

For those lines where the same type of investment is reported on other schedules but do not have a fair value column, report the amount consistent with instructions for the following:

Line 899509999999 ...................................... Report BACV, Schedule DA, Part 1, Column 7
Line 960999999999 .......................................... Report Balance, Schedule E Part 1, Column 6
Line 91999999709999999 ............................ Schedule E, Part 2, Column 7

Column 6 ─ Book/Adjusted Carrying Value

The value reported for this column should be determined in a manner consistent with the instructions of other schedules for the lines shown below:

Lines 0019999999 through 225099999999 .... Schedule D, Part 1, Column 11
Lines 244019999999 through 244509999999 Schedule D, Part 2, Section 1, Column 8
Lines 244501999999 through 295989999999 Schedule D, Part 2, Section 2, Column 6
Line 889209999999 ...................................... Schedule A, Part 1, Column 9
Line 889309999999 ...................................... Schedule B, Part 1, Column 8
Line 889409999999 ...................................... Schedule BA, Part 1, Column 12
Line 889509999999 ...................................... Schedule DA, Part 1, Column 7
Line 960999999999 .......................................... Report Balance, Schedule E, Part 1, Column 6
Line 91999999709999999 ............................ Schedule E, Part 2, Column 7
**Column 7 – Maturity Date**

The maturity date reported for this column should be determined in a manner consistent with the instructions of other schedules for the lines shown below:

- Lines 0019999999 through 7250999999999...... Schedule D, Part 1, Column 22
- Line 8995099999999............................. Schedule DA, Part 1, Column 6
- Line 91999999709999999...................... Schedule E, Part 2, Column 6

The following lines are considered assets with no maturity date and should be left blank:

- Lines 714019999999 through 7345099999999...... Preferred Stock (Schedule D, Part 2, Section 1 type)
- Lines 745019999999 through 7959899999999...... Common Stock (Schedule D, Part 2, Section 2 type)
- Line 7969209999999............................... Real Estate (Schedule A type)
- Line 8793099999999............................... Mortgage Loans on Real Estate (Schedule B type)
- Line 8994099999999............................... Other Invested Assets (Schedule BA type)
- Line 9298099999999............................... Other Assets

**Detail Eliminated to Conserve Space**

**Column 11 – ISIN Identification**

The International Securities Identification Numbering (ISIN) system is an international standard set up by the International Organization for Standardization (ISO). It is used for numbering specific securities, such as stocks, bonds, options and futures. ISIN numbers are administered by a National Numbering Agency (NNA) in each of their respective countries, and they work just like serial numbers for those securities. Record the ISIN number only if no valid CUSIP, CINS or PPN exists to report in Column 1.

The ISIN reported for this column should be determined in a manner consistent with the instructions of other schedules for the lines shown below:

- Lines 0019999999 through 225099999999...... Schedule D, Part 1, Column 1
- Lines 244019999999 through 245099999999...... Schedule D, Part 2, Section 1, Column 1
- Lines 245019999999 through 759899999999...... Schedule D, Part 2, Section 2, Column 1

The ISIN number should be zero-filled for the following lines:

- Real Estate (Schedule A type)................................................................. 8692099999999
- Mortgage Loans on Real Estate (Schedule B type).............................. 8793099999999
- Other Invested Assets (Schedule BA type).............................................. 8994099999999
- Short-Term Invested Assets (Schedule DA, Part 1 type)........................ 9095099999999
- Cash (Schedule E, Part 1 type)............................................................ 9692099999999
- Cash Equivalents (Schedule E, Part 2 type)........................................... 9197099999999
- Other Assets......................................................................................... 9997980999999
### SCHEDULE DL – PART 2
**SEcurities lending collateral assets**

Reinvested Collateral Assets Owned December 31 Current Year

(Securities lending collateral assets included on Schedules A, B, BA, D, DB and E and not reported in aggregate on Line 10 of the asset page.)

---

**Detail Eliminated to Conserve Space**

<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
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<tbody>
<tr>
<td><strong>Bonds (Schedule D, Part 1):</strong></td>
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</tr>
<tr>
<td><strong>U.S. Governments</strong></td>
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<tr>
<td>Issuer Obligations</td>
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<tr>
<td>Residential Mortgage-Backed Securities</td>
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<td>Commercial Mortgage-Backed Securities</td>
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<td>Other Loan-Backed and Structured Securities</td>
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<tr>
<td>Subtotals – U.S. Governments</td>
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<tr>
<td>All Other Governments</td>
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<td>Issuer Obligations</td>
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<tr>
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<td>Commercial Mortgage-Backed Securities</td>
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<tr>
<td>Other Loan-Backed and Structured Securities</td>
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<td>Subtotals – All Other Governments</td>
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<tr>
<td><strong>U.S. States, Territories and Possessions (Direct and Guaranteed):</strong></td>
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<tr>
<td>Issuer Obligations</td>
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<td>Residential Mortgage-Backed Securities</td>
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<td><strong>U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed):</strong></td>
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<td>Issuer Obligations</td>
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<td>Commercial Mortgage-Backed Securities</td>
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<td>Other Loan-Backed and Structured Securities</td>
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<td>Subtotals – U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed)</td>
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<tr>
<td><strong>U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions:</strong></td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
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<tr>
<td>Residential Mortgage-Backed Securities</td>
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<td>Commercial Mortgage-Backed Securities</td>
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<td>Other Loan-Backed and Structured Securities</td>
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<tr>
<td><strong>Industrial and Miscellaneous (Unaffiliated):</strong></td>
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<td>Issuer Obligations</td>
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<td>Subtotals – Industrial and Miscellaneous (Unaffiliated)</td>
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</table>

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Other Loan-Backed and Structured Securities .......................... 34099999104999999
Subtotals – Industrial and Miscellaneous (Unaffiliated) ........ 38999999110999999

Hybrid Securities
Issuer Obligations................................................................. 42999999121999999
Residential Mortgage-Backed Securities.............................. 43999999122999999
Commercial Mortgage-Backed Securities.......................... 44999999123999999
Other Loan-Backed and Structured Securities ....................... 45999999124999999
Subtotals – Hybrid Securities .................................................. 48999999130999999

Parent, Subsidiaries and Affiliates
Issuer Obligations................................................................. 49999999141999999
Residential Mortgage-Backed Securities.............................. 50999999142999999
Commercial Mortgage-Backed Securities.......................... 51999999143999999
Other Loan-Backed and Structured Securities ....................... 52999999144999999
Affiliated Bank Loans – Issued .............................................. 53999999145999999
Affiliated Bank Loans – Acquired ........................................ 54999999146999999
Subtotals – Parent, Subsidiaries and Affiliates ....................... 55999999150999999

SVO Identified Funds
Exchange Traded Funds – as Identified by the SVO............... 57999999161999999
Bond Mutual Funds – as Identified by the SVO ..................... 58999999162999999
Subtotals – SVO Identified Funds ........................................... 59999999

Unaffiliated Bank Loans
Unaffiliated Bank Loans – Issued ......................................... 60999999181999999
Unaffiliated Bank Loans – Acquired ..................................... 61999999182999999
Subtotals – Unaffiliated Bank Loans .................................... 62999999190999999

Unaffiliated Certificates of Deposit ...................................... 20199999999

Total Bonds
Subtotals – Issuer Obligations ............................................... 63999999241999999
Subtotals – Residential Mortgage-Backed Securities ............. 64999999242999999
Subtotals – Commercial Mortgage-Backed Securities .......... 65999999243999999
Subtotals – Other Loan-Backed and Structured Securities .... 66999999244999999
Subtotals – SVO Identified Funds ........................................... 67999999245999999
Subtotals – Affiliated Bank Loans ......................................... 68999999246999999
Subtotals – Bank Loans ........................................................... 69999999247999999
Subtotals – Unaffiliated Certificates of Deposit .................... 24899999999
Subtotals – Total Bonds .......................................................... 70999999250999999

Stocks:

Preferred Stocks:

Industrial and Miscellaneous (Unaffiliated)
Perpetual Preferred ............................................................ 40199999999
Redeemable Preferred .......................................................... 40299999999
Subtotals – Industrial and Miscellaneous (Unaffiliated) ........ 41099999999

Parent, Subsidiaries and Affiliates
Perpetual Preferred ............................................................ 43199999999
Redeemable Preferred .......................................................... 43299999999
Subtotals – Parent, Subsidiaries and Affiliates ....................... 44099999999

Total Preferred Stocks ........................................................... 72999999999

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### Common Stocks:

#### Industrial and Miscellaneous (Unaffiliated):
- Publicly Traded: 501,999,999
- Other: 502,999,999
- Subtotals – Industrial and Miscellaneous (Unaffiliated): 510,999,999

#### Mutual Funds
- Designation Assigned by SVO: 531,999,999
- Designation Not Assigned by SVO: 532,999,999
- Subtotals – Mutual Funds: 540,999,999

#### Unit Investment Trusts
- Designation Assigned by SVO: 551,999,999
- Designation Not Assigned by SVO: 552,999,999
- Subtotals – Unit Investment Trusts: 560,999,999

#### Closed-End Funds
- Designation Assigned by SVO: 571,999,999
- Designation Not Assigned by SVO: 572,999,999
- Subtotals – Closed-End Funds: 580,999,999

#### Exchange Traded Funds: 581,999,999

### Parent, Subsidiaries and Affiliates:

#### Publicly Traded: 591,999,999

### Industrials and Miscellaneous (Unaffiliated): 749,999,999

### Parent, Subsidiaries and Affiliates: 759,999,999

### Mutual Funds: 540,999,999

### Unit Investment Trusts: 560,999,999

### Closed-End Funds: 580,999,999

### Exchange Traded Funds: 581,999,999

### Total Common Stocks: 7,989,999,999

### Real Estate (Schedule A): 86,999,999

### Mortgage Loans on Real Estate (Schedule B): 87,999,999

### Other Invested Assets (Schedule BA): 88,999,999

### Short-Term Invested Assets (Schedule DA, Part 1): 89,999,999

### Cash (Schedule E, Part 1): 90,999,999

### Cash Equivalents (Schedule E, Part 2): 91,999,999

### Other Assets: 92,999,999

### Totals: 99,999,999

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Column 1 – CUSIP Identification

CUSIP numbers for all purchased publicly issued securities are available from the broker’s confirmation or the certificate. For private placement securities, the NAIC has created a special number called a PPN to be assigned by the Standard & Poor’s CUSIP Bureau. For foreign securities, use a CINS that is assigned by the Standard & Poor’s CUSIP Bureau: www.cusip.com/cusip/index.htm.

For Lines 0019999999 through 2250999999, if no valid CUSIP, CINS or PPN number exists, then the CUSIP field should be zero-filled and a valid ISIN security number should be reported in (Column 11).

The CUSIP reported for this column should be same for the security as reported in other schedules for the lines shown below:

Lines 0019999999 through 2250999999 .............................. Schedule D, Part 1, Column 1
Lines 224019999999 through 224509999999 ................. Schedule D, Part 2, Section 1, Column 1
Lines 224501999999 through 225989999999 ................. Schedule D, Part 2, Section 2, Column 1
Line 889409999999 ......................................................... Schedule BA, Part 1, Column 1
Line 9199999990709999999 ........................................... Schedule E, Part 2, Column 1

The CUSIP number should be zero-filled for the following lines:

Real Estate (Schedule A) ................................................................. 869209999999
Mortgage Loans on Real Estate (Schedule B) .............................................. 879309999999
Short-Term Invested Assets (Schedule DA, Part 1) ........................................ 899509999999
Cash (Schedule E, Part 1) ........................................................................ 9609999999
Other Assets ............................................................................................... 929809999999

Detail Eliminated to Conserve Space

Column 4 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol reported for this column should be same for the security as reported in other schedules for the lines shown below:

Lines 0019999999 through 2250999999 .... Schedule D, Part 1, Column 6
Lines 224019999999 through 224509999999 Schedule D, Part 2, Section 1, Column 20
Lines 224501999999 through 225989999999 Schedule D, Part 2, Section 2, Column 17
Line 889409999999 Schedule BA, Part 1, Column 7
Line 879509999999 Schedule DA, Part 1, Column 22
Line 9199999990709999999 Schedule E, Part 2, Column 11

For Lines 869209999999, 879309999999, 960999999999 and 929809999999, the column should be left blank.

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol will be shown as one column on the printed but will be three sub-columns in the data table.

- NAIC Designation Column 4A
- NAIC Designation Modifier Column 4B
- SVO Administrative Symbol Column 4C

On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).

Column 5 – Fair Value

The value reported for this column should be same for the security as reported in other schedules for the lines shown below:

- Lines 0019999999 through 22509999999 ... Schedule D, Part 1, Column 9
- Lines 244019999999 through 245099999999 Schedule D, Part 2, Section 1, Column 10
- Lines 245019999999 through 295989999999 Schedule D, Part 2, Section 2, Column 8
- Line 869209999999 .................................. Schedule A, Part 1, Column 10
- Line 879309999999 .................................. FV of the underlying collateral Schedule B, Part 1
- Line 889409999999 .................................. Schedule BA, Part 1, Column 11

For those lines where the same investment is reported on other schedules but do not have a fair value column, report the amount in these columns in the other schedules for the lines shown below:

- Line 889509999999 ............................... Report BACV, Schedule DA, Part 1, Column 7
- Line 960999999999 ............................... Report Balance, Schedule E, Part 1, Column 6
- Line 91999999709999999 .......................... Report BACV, Schedule E, Part 2, Column 7

Column 6 – Book/Adjusted Carrying Value

The value reported for this column should be same for the security as reported in other schedules for the lines shown below:

- Lines 0019999999 through 22509999999 ... Schedule D, Part 1, Column 11
- Lines 244019999999 through 245099999999 Schedule D, Part 2, Section 1, Column 8
- Lines 245019999999 through 295989999999 Schedule D, Part 2, Section 2, Column 6
- Line 869209999999 ............................... Schedule A, Part 1, Column 9
- Line 879309999999 ............................... Schedule B, Part 1, Column 8
- Line 889409999999 ............................... Schedule BA, Part 1, Column 12
- Line 889509999999 ............................... Schedule DA, Part 1, Column 7
- Line 960999999999 ............................... Report Balance, Schedule E, Part 1, Column 6
- Line 91999999709999999 .......................... Schedule E, Part 2, Column 7
Column 7 – Maturity Date

The maturity date reported for this column should be same for the security as reported in other schedules for the lines shown below:

Lines 0199999999 through 22509999999 .... Schedule D, Part 1, Column 22
Line 895009999999 ........................................ Schedule DA, Part 1, Column 6
Line 91999999709999999 ............................ Schedule E, Part 2, Column 6

The following lines are considered assets with no maturity date and should be left blank:

Preferred Stock (Schedule D, Part 2, Section 1 type) 714019999999 through 734509999999
Common Stock (Schedule D, Part 2, Section 2 type) 745019999999 through 795989999999
Real Estate (Schedule A type) 869209999999
Mortgage Loans on Real Estate (Schedule B type) 879309999999
Other Invested Assets (Schedule BA type) 889409999999
Other Assets 929809999999

Detail Eliminated to Conserve Space

Column 11 – ISIN Identification

The International Securities Identification Numbering (ISIN) system is an international standard set up by the International Organization for Standardization (ISO). It is used for numbering specific securities, such as stocks, bonds, options and futures. ISIN numbers are administered by a National Numbering Agency (NNA) in each of their respective countries, and they work just like serial numbers for those securities. Record the ISIN number only if no valid CUSIP, CINS or PPN exists to report in Column 1.

The ISIN reported for this column should be same for the security as reported in other schedules for the lines shown below:

Lines 0199999999 through 22509999999 .... Schedule D, Part 1, Column 1
Lines 714019999999 through 734509999999 .... Schedule D, Part 2, Section 1, Column 1
Lines 745019999999 through 795989999999 .... Schedule D, Part 2, Section 2, Column 1
Lines 745019999999 through 795989999999 .... Schedule D, Part 2, Section 2, Column 1

The ISIN number should be zero-filled for the following lines:

Real Estate (Schedule A) ................................................................. 869209999999
Mortgage Loans on Real Estate (Schedule B) 879309999999
Other Invested Assets (Schedule BA) 889409999999
Short-Term Invested Assets (Schedule BA, Part 1) 899509999999
Cash (Schedule E, Part 1) .......................................................... 9609999999
Cash Equivalents (Schedule E, Part 2) 91999999709999999
Other Assets 929809999999
### SCHEDULE E – PART 1 – CASH

<table>
<thead>
<tr>
<th>Group or Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deposits in (insert number) depositories that do not exceed allowable limits in any one depository – Open Depositories</td>
<td>0199998</td>
</tr>
<tr>
<td>Totals – Open Depositories</td>
<td>0199999</td>
</tr>
<tr>
<td>Deposits in (insert number) depositories that do not exceed allowable limits in any one depository – Suspended Depositories</td>
<td>0299998</td>
</tr>
<tr>
<td>Totals – Suspended Depositories</td>
<td>0299999</td>
</tr>
<tr>
<td>Total Cash on Deposit</td>
<td>0399999</td>
</tr>
<tr>
<td>Cash in Company’s Office</td>
<td>0499999</td>
</tr>
<tr>
<td>Total Cash</td>
<td>0599999</td>
</tr>
</tbody>
</table>
## SCHEDULE E – PART 2 – CASH EQUIVALENTS

**Detail Eliminated to Conserve Space**

<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bonds:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>U.S. Governments</strong></td>
<td></td>
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<tr>
<td>Issuer Obligations</td>
<td>01999990019999999</td>
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<tr>
<td>Residential Mortgage-Backed Securities</td>
<td>02999990029999999</td>
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<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>03999990039999999</td>
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<tr>
<td>Other Loan-Backed and Structured Securities</td>
<td>04999990049999999</td>
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<tr>
<td>Subtotals – U.S. Governments</td>
<td>05999990109999999</td>
</tr>
<tr>
<td><strong>All Other Governments</strong></td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
<td>06999990219999999</td>
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<tr>
<td>Residential Mortgage-Backed Securities</td>
<td>07999990229999999</td>
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<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>08999990239999999</td>
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<tr>
<td>Other Loan-Backed and Structured Securities</td>
<td>09999990249999999</td>
</tr>
<tr>
<td>Subtotals – All Other Governments</td>
<td>10999990309999999</td>
</tr>
<tr>
<td><strong>U.S. States, Territories and Possessions (Direct and Guaranteed)</strong></td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
<td>11999990419999999</td>
</tr>
<tr>
<td>Residential Mortgage-Backed Securities</td>
<td>12999990429999999</td>
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<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>13999990439999999</td>
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<td>Other Loan-Backed and Structured Securities</td>
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<td>Subtotals – States, Territories and Possessions (Direct and Guaranteed)</td>
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<td><strong>U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed)</strong></td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
<td>15999990619999999</td>
</tr>
<tr>
<td>Residential Mortgage-Backed Securities</td>
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<td>Commercial Mortgage-Backed Securities</td>
<td>17999990639999999</td>
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<td>Other Loan-Backed and Structured Securities</td>
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<td>24999990709999999</td>
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<tr>
<td><strong>U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions</strong></td>
<td></td>
</tr>
<tr>
<td>Issuer Obligations</td>
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<td>Residential Mortgage-Backed Securities</td>
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<td>Commercial Mortgage-Backed Securities</td>
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<td>Other Loan-Backed and Structured Securities</td>
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<td>Subtotals – Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions</td>
<td>31999990909999999</td>
</tr>
<tr>
<td><strong>Industrial and Miscellaneous (Unaffiliated)</strong></td>
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<tr>
<td>Issuer Obligations</td>
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<td>Residential Mortgage-Backed Securities</td>
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<td>Commercial Mortgage-Backed Securities</td>
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<tr>
<td>Other Loan-Backed and Structured Securities</td>
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<td>Subtotals – Industrial and Miscellaneous (Unaffiliated)</td>
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Hybrid Securities

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<td>Residential Mortgage-Backed Securities</td>
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<td>Commercial-Backed Securities</td>
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<td>Other Loan-Backed and Structured Securities</td>
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Subtotal – Hybrid Securities 4899999

Parent, Subsidiaries and Affiliates Bonds

<table>
<thead>
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<th>Category</th>
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<tbody>
<tr>
<td>Issuer Obligations</td>
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<td>Residential Mortgage-Backed Securities</td>
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<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>5199999</td>
</tr>
<tr>
<td>Other Loan-Backed and Structured Securities</td>
<td>5299999</td>
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<tr>
<td>Affiliated Bank Loans – Issued</td>
<td>5399999</td>
</tr>
<tr>
<td>Affiliated Bank Loans – Acquired</td>
<td>5499999</td>
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</tbody>
</table>

Subtotals – Parent, Subsidiaries and Affiliates Bonds 5599999

SVO Identified Funds

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Exchange Traded Funds – as Identified by the SVO</td>
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<tr>
<td>Bond Mutual Funds – as Identified by the SVO</td>
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Subtotals – SVO Identified Funds 6099999

Unaffiliated Bank Loans

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Unaffiliated Bank Loans – Issued</td>
<td>6309999</td>
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<tr>
<td>Unaffiliated Bank Loans – Acquired</td>
<td>6499999</td>
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Subtotals – Unaffiliated Bank Loans 6599999

Total Bonds

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Subtotals – Issuer Obligations</td>
<td>7699999</td>
</tr>
<tr>
<td>Subtotals – Residential Mortgage-Backed Securities</td>
<td>7799999</td>
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<tr>
<td>Subtotals – Commercial Mortgage-Backed Securities</td>
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<tr>
<td>Subtotals – Other Loan-Backed and Structured Securities</td>
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</tr>
<tr>
<td>Subtotals – SVO Identified Funds</td>
<td>8099999</td>
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<tr>
<td>Subtotals – Affiliated Bank Loans</td>
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<tr>
<td>Subtotals – Unaffiliated Bank Loans</td>
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Subtotals – Bonds 8399999

Sweep Accounts

<table>
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<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Sweep Accounts</td>
<td>8499999</td>
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</tbody>
</table>

Exempt Money Market Mutual Funds – as Identified by SVO

<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>All Other Money Market Mutual Funds</td>
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Qualified Cash Pools Under SSAP No. 2R

<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Other Cash Equivalents</td>
<td>8699999</td>
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</tbody>
</table>

Total Cash Equivalents

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cash Equivalents</td>
<td>9999999</td>
</tr>
</tbody>
</table>

A money market fund shall be reported in this schedule as an Exempt Money Market Mutual Fund if such money market fund is identified by the SVO as meeting the required conditions found in Part Six, Section 2(b)(i) of the Purposes and Procedures Manual of the NAIC Investment Analysis Office. All money market mutual funds that are not identified by the SVO on the U.S. Direct Obligations/Full Faith and Credit Exempt List shall be reported in this schedule as an “all other money market mutual fund.”
Column 1 – CUSIP Identification

CUSIP identification is **required and valid only** for Exempt Money Market Mutual Funds – as Identified by SVO (Line 85999998209999999) and All Other Money Market Mutual Funds (Line 86999998309999999).

Column 11 – NAIC Designation Category

Provide the appropriate combination of NAIC Designation Equivalent (1 through 6) and NAIC Designation Modifier Equivalent (A through G) (see table below) for each security shown.

The NAIC Designation and NAIC Designation Modifier Equivalent should not be provided for the following lines:

- Sweep Accounts
- Exempt Money Market Mutual Funds – as Identified by the SVO
- All Other Money Market Mutual Funds
- Qualified Cash Pools Under SSAP No. 2R
- Other Cash Equivalents
- Exchange Traded Funds – as Identified by the SVO

The NAIC Designation Category will be two sub-columns in the data table.

- NAIC Designation Equivalent
- NAIC Designation Modifier Equivalent

NAIC Designation Equivalent:

For the NAIC Designation Equivalent, use the NAIC Designation that would have been used for the investment had it been reported on Schedule D, Part 1 if available. If no NAIC Designation is available, the reporting entity should use a Designation Equivalent most closely resembles their credit risk the investment.
NAIC Designation Modifier Equivalent:

Bonds (Lines 4100000001999999 through 6599991909999999)

Use the NAIC Designation Modifier that would have been used for the investment had it been reported on Schedule D, Part 1 if available.

If no NAIC Designation Modifier is available, the reporting entity should use a Designation Modifier Equivalent most closely resembles their credit risk the investment.

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments reporting an NAIC Designation 6, therefore, the NAIC Designation Modifier field should be left blank.

Refer to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* for the application of these codes.

The NAIC Designation Category Equivalent is the combination of NAIC Designation Equivalent and NAIC Designation Modifier Equivalent. Valid combinations of NAIC Designation Equivalent and NAIC Designation Modifier Equivalent for NAIC Designation Category Equivalent are shown below:

<table>
<thead>
<tr>
<th>NAIC Designation Equivalent</th>
<th>NAIC Designation Modifier Equivalent</th>
<th>NAIC Designation Category Equivalent</th>
</tr>
</thead>
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<td>B</td>
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<tr>
<td>6</td>
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<td>6</td>
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</table>

NAIC Designation Category Equivalent Footnote:

Provide the total book/adjusted carrying value amount by NAIC Designation Category Equivalent that represents the amount reported in Column 7.

The sum of the amounts reported for each NAIC Designation Category Equivalent in the footnote should equal Line 830999925099999999.
**SUMMARY INVESTMENT SCHEDULE**

<table>
<thead>
<tr>
<th>Line</th>
<th>Category</th>
<th>Description</th>
<th>Column 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.01</td>
<td>U.S. Governments</td>
<td>The value of all U.S. Government securities defined as U.S. Government Obligations as defined per the <em>Purposes and Procedures Manual of the NAIC Investment Analysis Office</em>. Column 1 should equal the Schedule D, Part 1, Line 05999990109999999.</td>
<td></td>
</tr>
<tr>
<td>1.02</td>
<td>All other Governments</td>
<td>The value of all investments issued by non-U.S. governments, including bonds of political subdivisions and special revenue. This includes bonds issued by utilities owned by non-U.S. governments and bonds fully guaranteed by non-U.S. governments. Column 1 should equal the Schedule D, Part 1, Line 10999990309999999.</td>
<td></td>
</tr>
<tr>
<td>1.03</td>
<td>U.S. States, Territories and Possessions, etc. Guaranteed</td>
<td>The value of general obligations of these entities (NAIC members), as well as bonds issued by utility companies owned by these entities. Column 1 should equal the Schedule D, Part 1, Line 14999990509999999.</td>
<td></td>
</tr>
<tr>
<td>1.04</td>
<td>U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed</td>
<td>The value of general obligations of cities, counties, townships, etc., as well as bonds issued by utility companies owned by these entities. Column 1 should equal the Schedule D, Part 1, Line 24999990709999999.</td>
<td></td>
</tr>
<tr>
<td>1.05</td>
<td>U.S. Special Revenue &amp; Special Assessment Obligations, etc. Non-Guaranteed</td>
<td>The value of those U.S. government issues not listed as “Securities That Are Considered “Exempt Obligations” For Purposes of Determining The Asset Valuation Reserve And The Risk-Based Capital Calculation” in the <em>Purposes and Procedures manual of the NAIC Investment Analysis Office</em>, yet included as “Filing Exemptions for Other U.S. Government Obligations”. This category also includes bonds that are issued by states, territories, possessions and other political subdivisions that are issued for a specific financing project rather than as general obligation bonds. Column 1 should equal the Schedule D, Part 1, Line 31999990909999999.</td>
<td></td>
</tr>
<tr>
<td>1.06</td>
<td>Industrial and Miscellaneous</td>
<td>The value of all non-governmental issues that do not qualify for some other bond category, including privatized (non-government ownership) utility companies. Column 1 should equal the Schedule D, Part 1, Line 38999990110999999.</td>
<td></td>
</tr>
</tbody>
</table>
Line 1.07 – Hybrid Securities

Include: The value of securities whose proceeds are accorded some degree of equity treatment by one or more of the nationally recognized statistical rating organizations and/or that are recognized as regulatory capital by the issuer’s primary regulatory authority.

Column 1 should equal the Schedule D, Part 1, Line 48999991309999999.

Line 1.08 – Parent, Subsidiaries and Affiliates

Include: The value of all affiliated debt securities as defined under SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities.

Column 1 should equal the Schedule D, Part 1, Line 55999991509999999.

Line 1.09 – SVO Identified Funds

Include: The value of all Bond Mutual Funds included on the “NAIC Bond Mutual Fund List” as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office and Exchange Traded Funds (ETF) included on the “SVO-Identified Bond ETF List” as published on the Securities Valuation Office Web page (https://www.naic.org/svo.htm) that the SVO has determined are in scope of SSAP No. 26R—Bonds and can be reported on Schedule D, Part 1 and the SVO assigned a NAIC Designation, NAIC Designation Category and SVO Administrative Symbol published in the NAIC’s AVS+ system per the instructions in the Purposes and Procedures Manual of the NAIC Investment Analysis Office on the Compilation and Publication of the SVO List of Investment Securities.

Column 1 should equal the Schedule D, Part 1, Line 60999991619999999.

Line 1.10 – Unaffiliated Bank Loans

Include: The value of all Unaffiliated Bank Loans that are within the scope of SSAP No. 26R—Bonds.

Column 1 should equal the Schedule D, Part 1, Line 66999991619999999.

Line 1.11 – Unaffiliated Certificates of Deposit

Include: The value of all Unaffiliated Certificates of Deposit that are within the scope of SSAP No. 26R—Bonds.

Column 1 should equal the Schedule D, Part 1, Line 2019999999.

Line 1.12 – Total Long-Term Bonds

Sum of Lines 1.1 to 1.11.

The amount reported in Column 1 should equal the amount reported in Line 1, Column 1, Page 2, Assets.

The amount reported in Column 3 should equal the amount reported in Line 1, Column 3, Page 2, Assets.
Line 2.01 – Preferred Stocks – Industrial and Miscellaneous (Unaffiliated)

Include: The value of all unaffiliated preferred stocks.

Column 1 should equal the Schedule D, Part 2, Section 1, Lines 8499999 plus 85999994109999999.

Line 2.02 – Preferred Stocks – Parent, Subsidiaries and Affiliates

Include: The value of all preferred stock securities as defined under SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities.

Column 1 should equal the Schedule D, Part 2, Section 1, Lines 8699999 plus 87999994409999999.

Line 2.03 – Total Preferred Stocks

Sum of Lines 2.01 to 2.02.

The amount reported in Column 1 should equal the amount reported in Line 2.1, Column 1, Page 2, Assets.

The amount reported in Column 3 should equal the amount reported in Line 2.1, Column 3, Page 2, Assets.

Line 3.01 – Common Stocks – Industrial and Miscellaneous (Unaffiliated) Publicly Traded

Include: The value of all investments in the common stock of unaffiliated entities. Publicly traded common stock includes, but is not limited to, equity securities traded on a public exchange, master limited partnerships trading as common stock and American deposit receipts only if the security is traded on the New York, American or NASDAQ exchanges, and publicly traded common stock warrants.

Exclude: Mutual funds that should be reported on Line 3.05.

Column 1 should equal the Schedule D, Part 2, Section 2, Line 90999995019999999.

Line 3.02 – Common Stocks – Industrial and Miscellaneous (Unaffiliated) Other

Include: The value of all industrial and miscellaneous common stock of unaffiliated entities not reported in Line 3.1. Includes, but is not limited to:

1. Equity securities not traded on a public exchange (e.g., private equities).

2. Master limited partnership common stock not traded on the New York, American or NASDAQ exchanges.

Exclude: Mutual funds that should be reported on Line 3.05.

Column 1 should equal the Schedule D, Part 2, Section 2, Line 91999995029999999.

Line 3.03 – Common Stocks – Parent, Subsidiary and Affiliates Publicly Traded

Include: The value of all investments in the common stock of affiliated entities. Publicly traded common stock includes, but is not limited to, equity securities traded on a public exchange, master limited partnerships trading as common stock and American deposit receipts only if the security is traded on the New York, American or NASDAQ exchanges, and publicly traded common stock warrants.
Column 1 should equal the Schedule D, Part 2, Section 2, Line 92999995919999999.

Line 3.04  –  Common Stocks – Parent, Subsidiary and Affiliates Other
Include: The value of all unaffiliated entities not reported in Line 3.03.
Column 1 should equal the Schedule D, Part 2, Section 2, Line 93999995929999999.

Line 3.05  –  Common Stocks – Mutual Funds
Include: The value of all investments in shares of funds regulated as mutual funds by the Securities and Exchange Commission reported on Schedule D, Part 2, Section 2.
Column 1 should equal the Schedule D, Part 2, Section 2, Line 94999995409999999.

Line 3.06  –  Common Stocks – Unit Investment Trusts
Include: The value of all investments in shares of funds regulated as unit investment trusts by the Securities and Exchange Commission reported on Schedule D, Part 2, Section 2.
Column 1 should equal the Schedule D, Part 2, Section 2, Line 95999995609999999.

Line 3.07  –  Common Stocks – Closed-End Funds
Include: The value of all investments in shares of funds regulated as closed-end funds by the Securities and Exchange Commission reported on Schedule D, Part 2, Section 2.
Column 1 should equal the Schedule D, Part 2, Section 2, Line 96999995809999999.

Line 3.08  –  Common Stocks – Exchange Traded Funds
Include: The value of all investments in shares of funds regulated as exchange traded funds by the Securities and Exchange Commission reported on Schedule D, Part 2, Section 2.
Column 1 should equal the Schedule D, Part 2, Section 2, Line 5819999999.

Line 3.0809  –  Total Common Stocks
Sum of Lines 3.01 to 3.0808.
The amount reported in Column 1 should equal the amount reported in Line 2.2, Column 1, Page 2, Assets.
The amount reported in Column 3 should equal the amount reported in Line 2.2, Column 3, Page 2, Assets.

Detail Eliminated to Conserve Space
SCHEDULE D – SUMMARY BY COUNTRY
LONG-TERM BONDS AND STOCKS OWNED DECEMBER 31 OF CURRENT YEAR

Enter summarized amounts in the appropriate columns by the specified major classifications, subdividing into United States, Canada, and Other Countries where applicable. For purposes of this schedule, investments in Other Countries are considered Foreign Investments. For the definition of Foreign Investment, and Domestic Investment, see instructions to the Supplemental Investment Risk Interrogatories.

Column 2 – Fair Value

For certain bonds, values other than actual market may appear in this column. (See Schedule D, Part 1 instructions for details.)

Exclude: Accrued interest.

Column 3 – Actual Cost

Include: Brokerage and other related fees, to the extent they do not exceed the fair market value at the date of acquisition.

Exclude: Accrued interest.

Lines 8 through 11 – Bonds – Industrial and Miscellaneous, SVO Identified Funds, Unaffiliated Bank Loans, Unaffiliated Certificates of Deposit and Hybrid Securities (Unaffiliated)

Include: Exchange Traded Funds – as Identified by the SVO reported in Schedule D, Part 1.

Unaffiliated Bank Loans reported on Schedule D, Part 1.

Unaffiliated Certificates of Deposits reported on Schedule D, Part 1.

Line 13 – Total Bonds

Columns 1, 2, 3, and 4, should agree with Columns 11, 9, 7 and 10, respectively, in Schedule D, Part 1.

Column 1 should equal Column 1, Line 1 of the Assets page.

Lines 14 through 17 – Preferred Stocks – Industrial and Miscellaneous (Unaffiliated)

Include: Exchange Traded Funds (ETFs) reported in Schedule D, Part 2, Section 1.

Line 19 – Total Preferred Stocks

Columns 1, 2 and 3 should agree with Columns 8, 10 and 11, respectively, in Schedule D, Part 2, Section 1.

Column 1 should equal Column 1, Line 2.1 of the Assets page.
Lines 20 through 23 – Common Stocks – Industrial and Miscellaneous (Unaffiliated), Mutual Funds, Unit Investment Trusts, Closed-End Funds and Exchange Traded funds

Include: Mutual funds reported in Schedule D, Part 2, Section 2.

Exclude: Exchange Traded Funds (ETFs) reported in Schedule D, Part 2, Section 1.

Line 25 – Total Common Stocks

Columns 1, 2 and 3 should agree with Columns 6, 8 and 9, respectively, in Schedule D, Part 2, Section 2.

Column 1 should equal Column 1, Line 2.2 of the Assets page.
## SCHEDULE D – PART 1A – SECTION 1

### QUALITY AND MATURITY DISTRIBUTION OF ALL BONDS OWNED DECEMBER 31

**By Major Type and NAIC Designation**

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**Detail Eliminated to Conserve Space**

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There are 14-15 sections to this schedule: Sections 1 through 10-11 for each of the 10-11 bond categories, Section 12-13 for total bonds current year, Section 12-13 for total bonds prior year, Section 13-14 for total bonds publicly traded and Section 14-15 for total bonds privately placed. The 10-11 bond categories combine corresponding subtotals from Schedule D, Part 1; Schedule DA, Part 1; and Schedule E, Part 2 as follows, and for each of those 10-11 bond categories, the total line for Column 7 of each section should equal the sum of the subtotal lines shown below:

### Section 1. U.S. Governments

- Line 0599999-0109999999 from Schedule D, Part 1, Column 11; Line 0599999 from Schedule DA, Part 1, Column 7; and Line 0599999 from Schedule E, Part 2, Column 7.

### Section 2. All Other Governments

- Lines 1099999-0309999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.

### Section 3. U.S. States, Territories and Possessions, Guaranteed

- Lines 1799999-0509999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.

### Section 4. U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed

- Lines 2499999-0709999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.

### Section 5. U.S. Special Revenue & Special Assessment Obligations, etc., Non-Guaranteed

- Lines 3199999-0909999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.

### Section 6. Industrial & Miscellaneous (Unaffiliated)

- Line 3899999-1109999999 from Schedule D, Part 1, Column 11; Line 3899999 from Schedule DA, Part 1, Column 7; and Line 3899999 from Schedule E, Part 2, Column 7.

### Section 7. Hybrid Securities

- Lines 4899999-1309999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.

### Section 8. Parent, Subsidiaries and Affiliates

- Lines 5599999-1509999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.
Section 9. SVO Identified Funds

Lines 6099999, 1619999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.

Section 10. Unaffiliated Bank Loans

Lines 6509999, 1909999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.

Section 11. Unaffiliated Certificates of Deposit

Lines 2019999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.

The quality designation used is the “NAIC Designation” that appears with each bond as listed in the Valuations of Securities. Include short-term and cash equivalent bonds in the category that most closely resembles their credit risk. For each Section 1 through 11, seven lines of information are shown, which are numbered in a format “X.Y” where the number “X” is the number of the section and the number “Y” is the order of the line within the section. The lines within each section are categorized as follows for Section “X”.

| X.1 | Highest Quality  (NAIC 1) |
| X.2 | High Quality  (NAIC 2) |
| X.3 | Medium Quality  (NAIC 3) |
| X.4 | Low Quality  (NAIC 4) |
| X.5 | Lower Quality  (NAIC 5) |
| X.6 | In or near default  (NAIC 6) |
| X.7 | Total for section |

Footnote (d)

Provide the total book/adjusted carrying value amount reported in Section 11, Column 1 by NAIC designation that represents the amount of securities reported in Schedule DA and Schedule E, Part 2.

The sum of the amounts by NAIC designation (NAIC 1, NAIC 2, NAIC 3, NAIC 4, NAIC 5 and NAIC 6) reported in the footnote should equal the sum of Schedule DA, Part 1, Column 7, Lines 8399999, 2509999999 plus Schedule E, Part 2, Column 7, Line 8399999, 2509999999.
There are 14-15 sections to this schedule: Sections 1 through 11 for each of the 14-11 bond categories, Section 12 for total bonds current year, Section 13-14 for total bonds prior year, Section 14-15 for total bonds publicly traded and Section 15 for total bonds privately placed. The 14-11 bond categories combine corresponding subtotals from Schedule D, Part 1; Schedule DA, Part 1; and Schedule E, Part 2 as follows, and for each of those 14-11 bond categories, the total line for Column 7 of each section should equal the sum of the subtotal lines shown below:

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Lines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>U.S. Governments</td>
<td>0599999 0109999999 from Schedule D, Part 1, Column 11; Line 0599999 from Schedule DA, Part 1, Column 7; and Line 0599999 from Schedule E, Part 2, Column 7.</td>
</tr>
<tr>
<td>2</td>
<td>All Other Governments</td>
<td>0209999 0309999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.</td>
</tr>
<tr>
<td>3</td>
<td>U.S. States, Territories and Possessions, Guaranteed</td>
<td>0709999 0509999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.</td>
</tr>
<tr>
<td>4</td>
<td>U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed</td>
<td>0409999 0709999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.</td>
</tr>
<tr>
<td>5</td>
<td>U.S. Special Revenue &amp; Special Assessment Obligations, etc. Non-guaranteed</td>
<td>0909999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.</td>
</tr>
<tr>
<td>6</td>
<td>Industrial &amp; Miscellaneous (Unaffiliated)</td>
<td>1009999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.</td>
</tr>
<tr>
<td>7</td>
<td>Hybrid Securities</td>
<td>1309999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.</td>
</tr>
<tr>
<td>8</td>
<td>Parent, Subsidiaries and Affiliates</td>
<td>1509999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.</td>
</tr>
<tr>
<td>9</td>
<td>SVO Identified Funds</td>
<td>1609999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.</td>
</tr>
</tbody>
</table>
Section 10. Unaffiliated Bank Loans

Lines 65000000-190000000 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.

Section 11. Unaffiliated Certificates of Deposit

Lines 2019999999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7; and Schedule E, Part 2, Column 7.

For each major section, the following subgroups, which are described in the Investment Schedules General Instructions, shall be presented by maturity category:

Sections 1 through 7:
- Issuer Obligations
- Residential Mortgage-Backed Securities
- Commercial Mortgage-Backed Securities
- Other Loan-Backed and Structured Securities

Sections 8:
- Issuer Obligations
- Residential Mortgage-Backed Securities
- Commercial Mortgage-Backed Securities
- Other Loan-Backed and Structured Securities
- Affiliated Bank Loans – Issued
- Affiliated Bank Loans – Acquired

Section 9:
- Exchange Traded Funds – as Identified by the SVO
- Bond Mutual Funds – as Identified by the SVO

Section 10:
- Unaffiliated Bank Loans – Issued
- Unaffiliated Bank Loans – Acquired

Section 11:
- Unaffiliated Certificates of Deposit

Sections 11 through 15:
- Issuer Obligations
- Residential Mortgage-Backed Securities
- Commercial Mortgage-Backed Securities
- Other Loan-Backed and Structured Securities
- SVO Identified Funds
- Affiliated Bank Loans
- Unaffiliated Bank Loans
- Unaffiliated Certificates of Deposit

Detail Eliminated to Conserve Space
### DEFAULT COMPONENT –
**BASIC CONTRIBUTION, RESERVE OBJECTIVE AND MAXIMUM RESERVE CALCULATIONS**

#### Line 9 — Total Long-Term Bonds

Column 1 should agree with Page 2, Line 1, Column 3 plus Schedule DL Part 1, Column 6, Line 70009999250999999.

#### Line 17 — Total Preferred Stocks

Column 1 should agree with Page 2, Line 2.1, Column 3 plus Schedule DL, Part 1, Column 6, Line 73099994509999999.

#### Lines 18 through 24 — Short-Term Bonds

Report the book/adjusted carrying value of all short-term bonds and other short-term fixed-income investments (Schedule DA, Part 1 (Lines 05999990109999999, 10999990309999999, 17999990509999999, 24999990709999999, 31999990909999999, 38999991109999999, 48999991309999999, 55999991509999999, 60999991609999999 and 65999992019999999) and short-term bonds included on Schedule DL, Part 1, Line 89999999309999999 owned in Columns 1 and 4. Categorize the short-term bonds and other fixed-income instruments listed in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* into NAIC designations 1 through 6 as directed by the Securities Valuation Office instructions, except that exempt obligations listed in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* should be reported separately. Multiply the amount in Column 4 for each designation by the reserve factors provided in Columns 5, 7 and 9, and report the products by designation in Columns 6, 8 and 10, respectively.

#### Line 58 — Total Schedule B Mortgage Loans on Real Estate

Column 1 should agree with Page 2, Line 3.1 + 3.2, Column 3 plus Schedule DL, Part 1, Column 6, Line 87999999309999999.

#### Line 59 — Total Schedule DA Mortgages

Report the book/adjusted carrying value of all Schedule DA mortgage loans (Lines 84999999701999999 and 87999999309999999) and any applicable investments from Schedule DL, Part 1, Line 89999999309999999 owned in Column 1. Any related encumbrances should be deducted in Column 2. Multiply the amount in Column 4 by the reserve factors for the Schedule B mortgages and report the products in Columns 6, 8 and 10.
BASIC CONTRIBUTION, RESERVE OBJECTIVE AND MAXIMUM RESERVE CALCULATIONS FOR UNRATED MULTI-CLASS SECURITIES ACQUIRED BY CONVERSION

Line 17 – Total Common Stocks

Column 1 should agree with Page 2, Line 2.2, Column 3 plus Schedule DL, Part 1, Column 6, Line 77999995989999999. The Columns 6, 8 and 10 amounts, respectively, must be reported on the Asset Valuation Reserve Page, Lines 7, 10 and 9, respectively, Column 4.

Lines 18 through 20 – Real Estate

Categorize the real estate as indicated on Lines 18 through 20. Real estate reported in Schedule DL, Part 1, Line 8699999 9209999999 would also be included in this section. Report the sum of Columns 1, 2 and 3 in Column 4. Multiply the amount in Column 4 by the reserve factors provided in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively.

NOTE: Related party encumbrances are loans from the reporting entity and the amount reflected in Column 2 should be deducted in Column 2 in the corresponding section of the AVR worksheet. If the real estate entity to which the loan was made is not wholly owned by the reporting entity, the related party encumbrance amount reflected in Column 2 should be based on the reporting entity’s ownership percentage. The amount of the third party encumbrances without recourse to be reflected in Column 3 is limited to the extent that the maximum reserve (Column 6) should not exceed the sum of the book/adjusted carrying value (Column 1) plus related party encumbrances (Column 2) and third party encumbrances with recourse which are included in Column 3.

Line 83 – Other Invested Assets – Schedule BA

Report the book/adjusted carrying value of all other Schedule BA investments owned that cannot be classified into one of the above categories (Lines 0199999, 0299999, 0399999, 0499999, 0599999, 0699999, 0999999, 1099999, 1799999, 1899999, 2599999, 2699999, 2799999, 2899999, 3399999, 3499999, 3999999, 4699999 and 4799999) in Column 1 and any encumbrances on these assets in Column 3. Schedule DL, Part 1 investments reported on Line 8699999 9409999999 would be included in this total if not classified in one of the above categories. Collateral loans (Lines 2999999 and 3099999) have been intentionally excluded from this total. For surplus debentures and capital notes, the amount to report in Column 1 is to be calculated based upon the accounting prescribed in SSAP No. 41—Surplus Notes. Report the sum of Columns 1 and 3 in Column 4. Column 4 may not be less than zero. Note that ALL surplus debentures and capital notes should be included here in Line 83, EXCEPT those with a CRP rating equivalent to an NAIC 1 or NAIC 2 designation (which are reported in Lines 30 and 31 of this schedule). Multiply the amount in Column 4 by the reserve factors provided in Columns 5, 7 and 9, and report the products in Columns 6, 8 and 10, respectively.

Exclude: All surplus debentures and capital notes that possess a CRP rating equivalent to an NAIC 1 or NAIC 2 designation. These surplus debentures are to be reported in Line 30 and 31 (Other Invested Assets with Underlying Characteristics of Preferred Stocks) of this schedule.
Line 84 – Other Short-Term Invested Assets – Schedule DA

Report the book/adjusted carrying value of all other Schedule DA (Lines 8509999702999999 and 7029999999) and Schedule DL, Part 1 (Line 85099999509999999) assets owned that cannot be classified into one of the above categories in Column 1 and any encumbrances on these assets in Column 3. Report the sum of Columns 1 and 3 in Column 4. Multiply the amount on Column 4 by the reserve factors provided in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively.

Detail Eliminated to Conserve Space
### SCHEDULE D – PART 3

#### LONG-TERM BONDS AND STOCKS ACQUIRED DURING THE CURRENT QUARTER

<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bonds:</strong></td>
<td></td>
</tr>
<tr>
<td>U.S. Governments</td>
<td>05999990109999999</td>
</tr>
<tr>
<td>All Other Governments</td>
<td>10999990309999999</td>
</tr>
<tr>
<td>U.S. States, Territories and Possessions</td>
<td>17999990509999999</td>
</tr>
<tr>
<td>U.S. Political Subdivisions of States, Territories and Possessions</td>
<td>24999990709999999</td>
</tr>
<tr>
<td>U.S. Special Revenue and Special Assessment and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions</td>
<td>31999990909999999</td>
</tr>
<tr>
<td>Industrial and Miscellaneous (Unaffiliated)</td>
<td>38999991109999999</td>
</tr>
<tr>
<td>Hybrid Securities</td>
<td>48999991309999999</td>
</tr>
<tr>
<td>Parent, Subsidiaries and Affiliates</td>
<td>55999991509999999</td>
</tr>
<tr>
<td>SVO Identified Funds</td>
<td>80999991619999999</td>
</tr>
<tr>
<td>Unaffiliated Bank Loans</td>
<td>82999991909999999</td>
</tr>
<tr>
<td>Unaffiliated Certificates of Deposit</td>
<td>82999992019999999</td>
</tr>
<tr>
<td>Subtotals – Bonds – Part 3</td>
<td>83999972509999997</td>
</tr>
<tr>
<td>Summary Item from Part 5 for Bonds (N/A to Quarterly)</td>
<td>83999982509999998</td>
</tr>
<tr>
<td>Subtotals – Bonds</td>
<td>83999992509999999</td>
</tr>
</tbody>
</table>

| Preferred Stocks: | |  
| **Industrial and Miscellaneous (Unaffiliated)** | 84999994019999999 |
| Industrial and Miscellaneous (Unaffiliated) Perpetual Preferred | 84999994019999999 |
| Industrial and Miscellaneous (Unaffiliated) Redeemable Preferred | 85999994029999999 |
| **Parent, Subsidiaries and Affiliates** | 86999994319999999 |
| Parent, Subsidiaries and Affiliates Perpetual Preferred | 86999994319999999 |
| Parent, Subsidiaries and Affiliates Redeemable Preferred | 87999994329999999 |
| Subtotals – Preferred Stocks – Part 3 | 89999974509999997 |
| Summary Item from Part 5 for Preferred Stocks (N/A to Quarterly) | 89999984509999998 |
| Subtotals – Preferred Stocks | 89999994509999999 |

| Common Stocks: | |  
| **Industrial and Miscellaneous (Unaffiliated)** | 90999995019999999 |
| Industrial and Miscellaneous (Unaffiliated) Publicly Traded | 90999995019999999 |
| Industrial and Miscellaneous (Unaffiliated) Other | 91999995029999999 |
| **Mutual Funds** | |  
| Designations Assigned by the SVO | 5319999999 |
| Designations Not Assigned by the SVO | 5329999999 |
| **Unit Investment Trusts** | |  
| Designations Assigned by the SVO | 5519999999 |
| Designations Not Assigned by the SVO | 5529999999 |
| **Closed-End Funds** | |  
| Designations Assigned by the SVO | 5719999999 |
| Designations Not Assigned by the SVO | 5729999999 |
| **Exchange Traded Funds** | |  
| | 5819999999 |
**Parent, Subsidiaries and Affiliates**

- **Parent, Subsidiaries and Affiliates - Publicly Traded** ............................................................... 92999995919999999
- **Parent, Subsidiaries and Affiliates - Other** ............................................................................... 93999995929999999
- **Mutual Funds** ..................................................................................................................................................... 9499999
- **Unit Investment Trusts** ...................................................................................................................................... 9599999
- **Closed-End Funds** ............................................................................................................................................. 9699999
- **Subtotals – Common Stocks – Part 3** ............................................................................................ 97999975989999997
- **Summary Item from Part 5 for Common Stocks (N/A to Quarterly)** ............................................ 97999985989999998
- **Subtotals – Common Stocks** .......................................................................................................... 97999995989999999
- **Subtotals – Preferred and Common Stocks** ................................................................................... 98999995999999999

**Totals** ........................................................................................................................................................... 99999996009999999

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**Detail Eliminated to Conserve Space**

Column 10 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

Provide the appropriate combination of NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol (see below) at the end of the quarter for each security shown. The list of valid SVO Administrative Symbols is shown below.

The listing of valid NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol combinations can be found on the NAIC’s website for the Securities Valuation Office (www.naic.org/svo.htm).

Exchange Traded Funds – as Identified by the SVO should be reported as perpetual securities.

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol will be shown as one column on the printed schedule but will be three sub-columns in the data table.

- NAIC Designation Column 10A
- NAIC Designation Modifier Column 10B
- SVO Administrative Symbol Column 10C

On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).

**NAIC Designation Modifier:**

The NAIC Designation Modifier should only be used for securities reported on the lines below if eligible to receive one, as defined in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual), otherwise, should not be provided.

- Bonds Lines 0199999 0109999999 through 82999992019999999
- Preferred Stocks Lines 8499999 4019999999 and 85999994029999999

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Common Stocks Lines 0499999 5319999999, 5519999999 through and 0699999 5719999999

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments reporting an NAIC Designation 6, therefore, the NAIC Designation Modifier should not be provided.

For securities reported on Line 0499999 5319999999 (Mutual Funds Designation Assigned by SVO), Line 0599999 5519999999 (Unit Investment Trusts Designation Assigned by SVO) and Line 0699999 5719999999 (Closed-End Funds Designation Assigned by SVO) provide the appropriate NAIC Designation and NAIC Modifier as assigned by the Securities Valuation Office. NAIC Designation and NAIC Designation Modifier should not be provided for securities reported on these lines that have not been assigned one by the Securities Valuation Office and published in AVS+ per the instructions in the Purposes and Procedures Manual of the NAIC Investment Analysis Office on the Compilation and Publication of the SVO List of Investment Securities. For all other common stock line categories, the NAIC designation and NAIC Modifier a should not be provided.

Refer to the P&P Manual for the application of these modifiers.

SVO Administrative Symbol:

Long Term Bond:

Following are valid SVO Administrative Symbols for bonds. Refer to the P&P Manual for the application of these symbols.

S Additional or other non-payment risk
SYE Additional or other non-payment risk - Year-end carry over
FE Filing Exempt
FM Financially Modeled RMBS/CMBS subject to SSAP 43R
YE Year-end carry over
IF Initial filing
PL Private Letter Rating
PLGI Private Letter Rating – General Interrogatory
RT Regulatory Transaction
RTS Regulatory Transaction - SVO Reviewed
RTIF Regulatory Transaction - Initial Filing Submitted to SVO
RTSYE Regulatory Transaction - SVO Reviewed - Year-end carry over
GI General Interrogatory
F Sub-paragraph D Company – insurer self-designated
Z Insurer self-designated
* Limited to NAIC Designations 6
Z* Regulatory review initiated by either the SVO Director, Financial Condition (E) Committee, Executive (EX) Committee or VOSTF.
ND* Regulatory review for an assessment of regulatory policy for the investment or regulatory reporting instructions to implement applicable policy.
Preferred Stock:

Following are valid SVO Administrative Symbols for preferred stock. Refer to the P&P Manual for the application of these symbols.

S Additional or other non-payment risk
SYE Additional or other non-payment risk - Year-end carry over
FE Filing Exempt
YE Year-end carry over
IF Initial filing
PL Private Letter Rating
PLGI Private Letter Rating – General Interrogatory
RT Regulatory Transaction
RTS Regulatory Transaction - SVO Reviewed
RTIF Regulatory Transaction - Initial Filing Submitted to SVO
RTSYE Regulatory Transaction - SVO Reviewed - Year-end carry over
GI General Interrogatory
F Sub-paragraph D Company – insurer self-designated
Z Insurer self-designated
* Limited to NAIC Designations 6
Z* Regulatory review initiated by either the SVO Director, Financial Condition (E) Committee, Executive (EX) Committee or VOSTF.
ND* Regulatory review for an assessment of regulatory policy for the investment or regulatory reporting instructions to implement applicable policy.

Common Stock:

Following are valid SVO Administrative Symbols for common stock. Refer to the P&P Manual for the application of these symbols.

YE Year-end carry over
Z* Regulatory review initiated by either the SVO Director, Financial Condition (E) Committee, Executive (EX) Committee or VOSTF.
ND* Regulatory review for an assessment of regulatory policy for the investment or regulatory reporting instructions to implement applicable policy.
The NAIC Designation Category is the combination of NAIC Designation and NAIC Designation Modifier. Valid combinations of NAIC Designation and NAIC Designation Modifier for NAIC Designation Category are shown below:

<table>
<thead>
<tr>
<th>NAIC Designation</th>
<th>NAIC Designation Modifier</th>
<th>NAIC Designation Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>1A</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>1B</td>
</tr>
<tr>
<td></td>
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Detail Eliminated to Conserve Space
**SCHEDULE D – PART 4**

**LONG-TERM BONDS AND STOCKS SOLD, REDEEMED OR OTHERWISE DISPOSED OF DURING THE CURRENT QUARTER**

<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
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<tbody>
<tr>
<td>Bonds:</td>
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<tr>
<td>U.S. Governments</td>
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<td>All Other Governments</td>
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<td>U.S. States, Territories and Possessions</td>
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<td>U.S. Political Subdivisions of States, Territories and Possessions</td>
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<td>U.S. Special Revenue and Special Assessment and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions</td>
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<td>Industrial and Miscellaneous (Unaffiliated)</td>
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<td>Hybrid Securities</td>
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<td>Unaffiliated Bank Loans</td>
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<td>Unaffiliated Certificates of Deposit</td>
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<td>Subtotals – Bonds – Part 4</td>
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<td>Summary Item from Part 5 for Bonds (N/A to Quarterly)</td>
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<td>Subtotals – Bonds</td>
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<td>Preferred Stocks:</td>
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<td>Industrial and Miscellaneous (Unaffiliated)</td>
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<td>Parent, Subsidiaries and Affiliates Redeemable Preferred</td>
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<td>Subtotals – Preferred Stocks</td>
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<td>Common Stocks:</td>
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<td>Industrial and Miscellaneous (Unaffiliated)</td>
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<td>Designations Not Assigned by the SVO</td>
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<td>Closed-End Funds</td>
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<td>Designations Assigned by the SVO</td>
<td>5719999999</td>
</tr>
</tbody>
</table>
Column 22 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

Provide the appropriate combination of the NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol (see below) at date of disposal for each security shown. The list of valid SVO Administrative Symbols is shown below.

Where multiple disposal transactions occurred for the same CUSIP, and those transactions are summarized on one line, enter the appropriate combination of NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol for the last disposal using the last available designation.

The listing of valid NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol combinations can be found on the NAIC’s website for the Securities Valuation Office (www.naic.org/svo.htm).

Exchange Traded Funds – as Identified by the SVO should be reported as perpetual securities.

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol will be shown as one column on the printed but will be three sub-columns in the data table.

- NAIC Designation Column 22A
- NAIC Designation Modifier Column 22B
- SVO Administrative Symbol Column 22C

On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).

NAIC Designation Modifier:

The NAIC Designation Modifier should only be used for securities reported on the lines below if eligible to receive one, as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), otherwise, should not be provided.

- Bonds Lines 01999999 through 02999999
- Preferred Stocks Lines 40099999 through 40299999
- Common Stocks Lines 04999999 through 57999999

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As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments reporting an NAIC Designation 6, therefore, the NAIC Designation Modifier should not be provided.

For securities reported on Line 9499999 5319999999 (Mutual Funds Designation Assigned by SVO), Line 9599999 5519999999 (Unit Investment Trusts Designation Assigned by SVO) and Line 9699999 5719999999 (Closed-End Funds Designation Assigned by SVO) provide the appropriate NAIC Designation and NAIC Modifier as assigned by the Securities Valuation Office. NAIC Designation and NAIC Designation Modifier should not be provided for securities reported on these lines that have not been assigned one by the Securities Valuation Office and published in AVS+ per the instructions in the Purposes and Procedures Manual of the NAIC Investment Analysis Office on the Compilation and Publication of the SVO List of Investment Securities. For all other common stock line categories, the NAIC designation and NAIC Modifier a should not be provided.

Refer to the P&P Manual for the application of these modifiers.

SVO Administrative Symbol:

Long Term Bond:

Following are valid SVO Administrative Symbols for bonds. Refer to the P&P Manual for the application of these symbols

- S: Additional or other non-payment risk
- SYE: Additional or other non-payment risk - Year-end carry over
- FE: Filing Exempt
- FM: Financially Modeled RMBS/CMBS subject to SSAP 43R
- YE: Year-end carry over
- IF: Initial filing
- PL: Private Letter Rating
- PLGI: Private Letter Rating – General Interrogatory
- RT: Regulatory Transaction
- RTS: Regulatory Transaction - SVO Reviewed
- RTIF: Regulatory Transaction - Initial Filing Submitted to SVO
- RTSYE: Regulatory Transaction - SVO Reviewed - Year-end carry over
- GI: General Interrogatory
- F: Sub-paragraph D Company – insurer self-designated
- Z: Insurer self-designated
- *: Limited to NAIC Designation 6
- Z*: Regulatory review initiated by either the SVO Director, Financial Condition (E) Committee, Executive (EX) Committee or VOSTF.
- ND*: Regulatory review for an assessment of regulatory policy for the investment or regulatory reporting instructions to implement applicable policy.
Preferred Stock:

Following are valid administrative symbols for preferred stock.

S Additional or other non-payment risk
SYE Additional or other non-payment risk - Year-end carry over
FE Filing Exempt
YE Year-end carry over
IF Initial filing
PL Private Letter Rating
PLGI Private Letter Rating – General Interrogatory
RT Regulatory Transaction
RTS Regulatory Transaction - SVO Reviewed
RTIF Regulatory Transaction - Initial Filing Submitted to SVO
RTSYE Regulatory Transaction - SVO Reviewed - Year-end carry over
GI General Interrogatory
F Sub-paragraph D Company – insurer self-designated
Z Insurer self-designated
* Limited to NAIC Designation 6
Z* Regulatory review initiated by either the SVO Director, Financial Condition (E) Committee, Executive (EX) Committee or VOSTF.
ND* Regulatory review for an assessment of regulatory policy for the investment or regulatory reporting instructions to implement applicable policy.

Common Stock:

Following are valid SVO Administrative Symbols for common stock. Refer to the P&P Manual for the application of these symbols.

YE Year-end carry over
Z* Regulatory review initiated by either the SVO Director, Financial Condition (E) Committee, Executive (EX) Committee or VOSTF.
ND* Regulatory review for an assessment of regulatory policy for the investment or regulatory reporting instructions to implement applicable policy.
The NAIC Designation Category is the combination of NAIC Designation and NAIC Designation Modifier. Valid combinations of NAIC Designation and NAIC Designation Modifier for NAIC Designation Category are shown below:

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### SCHEDULE DL – PART 1

**SECURITIES LENDING COLLATERAL ASSETS**

Reinvested Collateral Assets Owned Current Statement Date

(Securities lending collateral assets reported in aggregate on Line 10 of the asset page and not included on Schedules A, B, BA, D, DB and E.)

**Detail Eliminated to Conserve Space**

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<th>Category</th>
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<td>Commercial Mortgage-Backed Securities</td>
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<td>All Other Governments</td>
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<td>Commercial Mortgage-Backed Securities</td>
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<td>Other Loan-Backed and Structured Securities</td>
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<td>Subtotals – All Other Governments</td>
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<td>U.S. States, Territories and Possessions (Direct and Guaranteed)</td>
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<td>U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions</td>
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<td>Commercial Mortgage-Backed Securities</td>
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<td>Other Loan-Backed and Structured Securities</td>
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<td>Issuer Obligations</td>
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<td>Preferred Stocks (Schedule D, Part 2, Section 1 type):</td>
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## Common Stocks (Schedule D, Part 2, Section 2 type):

### Industrial and Miscellaneous (Unaffiliated):
- Publicly Traded: 5019999999
- Other: 5029999999
- Subtotals – Industrial and Miscellaneous (Unaffiliated): 5109999999

### Mutual Funds
- Designation Assigned by SVO: 5319999999
- Designation Not Assigned by SVO: 5329999999
- Subtotals – Mutual Funds: 5409999999

### Unit Investment Trusts
- Designation Assigned by SVO: 5519999999
- Designation Not Assigned by SVO: 5529999999
- Subtotals – Unit Investment Trusts: 5609999999

### Closed-End Funds
- Designation Assigned by SVO: 5719999999
- Designation Not Assigned by SVO: 5729999999
- Subtotals – Closed-End Funds: 5809999999

### Parent, Subsidiaries and Affiliates
- Publicly Traded: 5919999999
- Other: 5929999999
- Subtotals – Parent, Subsidiaries and Affiliates: 5979999999

### Total Common Stocks: 7999999999

## Total Preferred and Common Stocks: 8099999999

## Real Estate (Schedule A type): 8699999999
- Mortgage Loans on Real Estate (Schedule B type): 8799999999
- Other Invested Assets (Schedule BA type): 8899999999
- Short-Term Invested Assets (Schedule DA type): 8999999999
- Cash (Schedule E, Part 1 type): 9099999999
- Cash Equivalents (Schedule E, Part 2 type): 9199999999
- Other Assets: 9299999999
- Totals: 9999999999
Column 1  —  CUSIP Identification

CUSIP numbers for all purchased publicly issued securities are available from the broker’s confirmation or the certificate. For private placement securities, the NAIC has created a special number called a PPN to be assigned by the Standard & Poor’s CUSIP Bureau. For foreign securities, use a CINS that is assigned by the Standard & Poor’s CUSIP Bureau: www.cusip.com/cusip/index.htm.

For Lines 00019999999 through 22509999999, if no valid CUSIP, CINS or PPN number exists, then the CUSIP field should be zero-filled and a valid ISIN security number should be reported in Column 11.

The CUSIP reported for this column should be determined in a manner consistent with the instructions of other schedules for the lines shown below:

Lines 00019999999 through 22509999999 ...................... Schedule D, Part 1, Column 1
Lines 224019999999 through 224509999999 .................. Schedule D, Part 2, Section 1, Column 1
Lines 225019999999 through 225989999999 .................. Schedule D, Part 2, Section 2, Column 1
Line 889409999999 ...................................................... Schedule BA, Part 1, Column 1
Line 01999999970999999 ............................................. Schedule E, Part 2, Column 1

The CUSIP number should be zero-filled for the following lines:

- Real Estate (Schedule A type) ................................................................. 869209999999
- Mortgage Loans on Real Estate (Schedule B type).............................. 879309999999
- Short-Term Invested Assets (Schedule DA, Part 1 type).......................... 899509999999
- Cash (Schedule E, Part 1 type).............................................................. 960999999999
- Other Assets ......................................................................................... 929809999999

---

Column 4  —  NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol reported for this column should be determined in a manner consistent with the instructions of other schedules for the lines shown below:

Lines 00019999999 through 22509999999 .... Schedule D, Part 1, Column 6
Lines 224019999999 through 224509999999 Schedule D, Part 2, Section 1, Column 20
Lines 225019999999 through 225989999999 Schedule D, Part 2, Section 2, Column 17
Line 889409999999 Schedule BA, Part 1, Column 7
Line 899509999999 Schedule DA, Part 1, Column 22
Line 91999999709999999 Schedule E, Part 2, Column 11

For Lines 869209999999, 879309999999, 960999999999 and 929809999999, the column should be left blank.

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol will be shown as one column on the printed schedule but will be three sub-columns in the data table.

- NAIC Designation Column 4A
- NAIC Designation Modifier Column 4B
On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).

Column 5 – Fair Value

The value reported for this column should be determined in a manner consistent with the fair value column instructions of other schedules for the lines shown below:

- Lines 0019999999 through 2509999999 – Schedule D, Part 1, Column 9
- Lines 74401999999 through 74450999999 – Schedule D, Part 2, Section 1, Column 10
- Lines 744501999999 through 74509899999 – Schedule D, Part 2, Section 2, Column 8
- Line 86209999999 – Schedule A, Part 1, Column 10
- Line 87309999999 – FV of the underlying collateral Schedule B, Part 1
- Line 88409999999 – Schedule BA, Part 1, Column 11

For those lines where the same type of investment is reported on other schedules but do not have a fair value column, report the amount consistent with instructions for the following:

- Line 89509999999 – Report BACV, Schedule DA, Column 7
- Line 96099999999 – Report Balance, Schedule E Part 1, Column 6
- Line 91999999709999999 – Report BACV, Schedule E Part 2, Column 7

Column 6 – Book/Adjusted Carrying Value

The value reported for this column should be determined in a manner consistent with the instructions of other schedules for the lines shown below:

- Lines 0119999999 through 2509999999 – Schedule D, Part 1, Column 11
- Lines 74401999999 through 74450999999 – Schedule D, Part 2, Section 1, Column 11
- Lines 744501999999 through 74509899999 – Schedule D, Part 2, Section 2, Column 6
- Line 86209999999 – Schedule A, Part 1, Column 9
- Line 87309999999 – Schedule B, Part 1, Column 8
- Line 88409999999 – Schedule BA, Part 1, Column 12
- Line 89509999999 – Schedule DA, Part 1, Column 7
- Line 96099999999 – Report Balance, Schedule E Part 1, Column 6
- Line 91999999709999999 – Schedule E Part 2, Column 7

Column 7 – Maturity Date

The maturity date reported for this column should be determined in a manner consistent with the instructions of other schedules for the lines shown below:

- Lines 0119999999 through 2509999999 – Schedule D, Part 1, Column 22
- Line 89509999999 – Schedule DA, Column 6
- Line 91999999709999999 – Schedule E Part 2, Column 6
The following lines are considered assets with no maturity date and should be left blank:

- Preferred Stock (Schedule D, Part 2, Section 1 type)
- Common Stock (Schedule D, Part 2, Section 2 type)
- Real Estate (Schedule A type)
- Mortgage Loans on Real Estate (Schedule B type)
- Other Invested Assets (Schedule BA type)

** Columns 8 and 9 will be electronic only. **

** Column 8 – Legal Entity Identifier (LEI) **

Provide the 20-character Legal Entity Identifier (LEI) for any mortgagor, issuer or counterparty as assigned by a designated Local Operating Unit. If no LEI number has been assigned, leave blank.

** Column 9 – ISIN Identification **

The International Securities Identification Numbering (ISIN) system is an international standard set up by the International Organization for Standardization (ISO). It is used for numbering specific securities, such as stocks, bonds, options and futures. ISIN numbers are administered by a National Numbering Agency (NNA) in each of their respective countries, and they work just like serial numbers for those securities. Record the ISIN number only if no valid CUSIP, CINS or PPN exists to report in Column 1.

The ISIN reported for this column should be determined in a manner consistent with the instructions of other schedules for the lines shown below:

- Schedule D, Part 1, Column 1
- Schedule D, Part 2, Section 1, Column 1
- Schedule D, Part 2, Section 2, Column 1

The ISIN number should be zero-filled for the following lines:

- Real Estate (Schedule A type)
- Mortgage Loans on Real Estate (Schedule B type)
- Other Invested Assets (Schedule BA type)
- Short-Term Invested Assets (Schedule DA, Part 1 type)
- Cash (Schedule E, Part 1 type)
- Cash Equivalents (Schedule E, Part 2 type)
- Other Assets
# SCHEDULE DL – PART 2

## SECURITIES LENDING COLLATERAL ASSETS

Reinvested Collateral Assets Owned Current Statement Date  
(Securities lending collateral assets included on Schedules A, B, BA, D, DB and E  
and not reported in aggregate on Line 10 of the asset page.)

---

**Detail Eliminated to Conserve Space**

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<tr>
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<td>Total Preferred Stocks</td>
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Common Stocks:

**Industrial and Miscellaneous (Unaffiliated):**
- Publicly Traded: 5019999999
- Other: 5029999999
- Subtotals – Industrial and Miscellaneous (Unaffiliated): 5109999999

**Mutual Funds**
- Designation Assigned by SVO: 5319999999
- Designation Not Assigned by SVO: 5329999999
- Subtotals – Mutual Funds: 5409999999

**Unit Investment Trusts**
- Designation Assigned by SVO: 5519999999
- Designation Not Assigned by SVO: 5529999999
- Subtotals – Unit Investment Trusts: 5609999999

**Closed-End Funds**
- Designation Assigned by SVO: 5719999999
- Designation Not Assigned by SVO: 5729999999
- Subtotals – Closed-End Funds: 5809999999

**Exchange Traded Funds**
- 5819999999

**Parent, Subsidiaries and Affiliates:**
- Publicly Traded: 5919999999
- Other: 5929999999
- Subtotals – Parent, Subsidiaries and Affiliates: 5979999999

**Industrial and Miscellaneous (Unaffiliated):**
- 7499999

**Parent, Subsidiaries and Affiliates:**
- 7599999

**Mutual Funds**
- 7609999

**Unit Investment Trusts**
- 7699999

**Closed-End Funds**
- 7809999

**Total Common Stocks:** 79999995989999999

**Total Preferred and Common Stocks:** 80999995999999999

**Real Estate (Schedule A):** 86999999209999999

**Mortgage Loans on Real Estate (Schedule B):** 87099999309999999

**Other Invested Assets (Schedule BA):** 88999999409999999

**Short-Term Invested Assets (Schedule DA):** 89999999509999999

**Cash (Schedule E, Part 1):** 90999999609999999

**Cash Equivalents (Schedule E, Part 2):** 91999999709999999

**Other Assets:** 92999999809999999

**Totals:** 9990999999
Column 1 – CUSIP Identification

CUSIP numbers for all purchased publicly issued securities are available from the broker’s confirmation or the certificate. For private placement securities, the NAIC has created a special number called a PPN to be assigned by the Standard & Poor’s CUSIP Bureau. For foreign securities, use a CINS that is assigned by the Standard & Poor’s CUSIP Bureau: [www.cusip.com/cusip/index.htm](http://www.cusip.com/cusip/index.htm).

For Lines 0019999999 through 22509999999, if no valid CUSIP, CINS or PPN number exists, then the CUSIP field should be zero-filled and a valid ISIN security number should be reported in Column 11.

The CUSIP reported for this column should be same for the security as reported in other schedules for the lines shown below:

- Lines 0019999999 through 22509999999 — Schedule D, Part 1, Column 1
- Lines 24019999999 through 24450999999 — Schedule D, Part 2, Section 1, Column 1
- Lines 24501999999 through 24598999999 — Schedule D, Part 2, Section 2, Column 1
- Line 88409999999 — Schedule D, Part 2, Section 2, Column 1
- Line 91999999709999999 — Schedule E, Part 2, Column 1

The CUSIP number should be zero-filled for the following lines:

- Real Estate (Schedule A) — 86920999999
- Mortgage Loans on Real Estate (Schedule B) — 87930999999
- Short-Term Invested Assets (Schedule DA, Part 1) — 89950999999
- Cash (Schedule E, Part 1) — 9609999999
- Other Assets — 92980999999

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**Detail Eliminated to Conserve Space**

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Column 4 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol reported for this column should be same for the security as reported in other schedules for the lines shown below:

- Lines 0019999999 through 22509999999 — Schedule D, Part 1, Column 6
- Lines 24019999999 through 24450999999 — Schedule D, Part 2, Section 1, Column 20
- Lines 24501999999 through 24598999999 — Schedule D, Part 2, Section 2, Column 17
- Line 88409999999 — Schedule BA, Part 1, Column 1
- Line 89950999999 — Schedule DA, Part 1, Column 1
- Line 91999999709999999 — Schedule E, Part 2, Column 11

For Lines 86920999999, 87930999999, 9609999999 and 92980999999, the column should be left blank.

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol will be shown as one column on the printed schedule but will be three sub-columns in the data table.

- NAIC Designation Column 4A
- NAIC Designation Modifier Column 4B
- Administrative Symbol Column 4C
On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).

**Column 5 — Fair Value**

The value reported for this column should be same for the security as reported in other schedules for the lines shown below:

- Lines 0019999999 through 2250999999 .... Schedule D, Part 1, Column 9
- Lines 24019999999 through 24509999999 Schedule D, Part 2, Section 1, Column 10
- Lines 24501999999 through 29508999999 Schedule D, Part 2, Section 2, Column 8
- Line 869209999999 ...................................... Schedule A, Part 1, Column 10
- Line 879309999999 ...................................... FV of the underlying collateral Schedule B, Part 1
- Line 889409999999 ...................................... Schedule BA, Part 1, Column 11

For those lines where the same investment is reported on other schedules but do not have a fair value column, report the amount in these columns in the other schedules for the lines shown below:

- Line 899509999999 ...................................... Report BACV, Schedule DA, Column 7
- Line 9609999999 .......................................... Report Balance, Schedule E, Part 1, Column 6
- Line 91999999709999999 .................................. Report BACV, Schedule E, Part 2, Column 7

**Column 6 — Book/Adjusted Carrying Value**

The value reported for this column should be same for the security as reported in other schedules for the lines shown below:

- Lines 0019999999 through 2250999999 .... Schedule D, Part 1, Column 11
- Lines 24019999999 through 24509999999 Schedule D, Part 2, Section 1, Column 8
- Lines 24501999999 through 29508999999 Schedule D, Part 2, Section 2, Column 6
- Line 869209999999 ...................................... Schedule A, Part 1, Column 9
- Line 879309999999 ...................................... Schedule BA, Part 1, Column 8
- Line 889409999999 ...................................... Schedule BA, Part 1, Column 12
- Line 899509999999 ...................................... Schedule DA, Part 1, Column 7
- Line 9609999999 .......................................... Schedule E, Part 1, Column 12
- Line 91999999709999999 .................................. Schedule E, Part 2, Column 7

**Column 7 — Maturity Date**

The maturity date reported for this column should be same for the security as reported in other schedules for the lines shown below:

- Lines 0019999999 through 2250999999 .... Schedule D, Part 1, Column 22
- Line 899509999999 ...................................... Schedule DA, Part 1, Column 6
- Line 91999999709999999 .................................. Schedule E, Part 2, Column 6

The following lines are considered assets with no maturity date and should be left blank:

- 244019999999 through 24509999999 ... Preferred Stock (Schedule D, Part 2, Section 1 type)
- 245019999999 through 295089999999 .... Common Stock (Schedule D, Part 2, Section 2 type)
Columns 8 and 9 will be electronic only. **

Column 8 — Legal Entity Identifier (LEI)

Provide the 20-character Legal Entity Identifier (LEI) for any mortgagor, issuer or counterparty as assigned by a designated Local Operating Unit. If no LEI number has been assigned, leave blank.

Column 9 — ISIN Identification

The International Securities Identification Numbering (ISIN) system is an international standard set up by the International Organization for Standardization (ISO). It is used for numbering specific securities, such as stocks, bonds, options and futures. ISIN numbers are administered by a National Numbering Agency (NNA) in each of their respective countries, and they work just like serial numbers for those securities. Record the ISIN number only if no valid CUSIP, CINS or PPN exists to report in Column 1.

The ISIN reported for this column should be same for the security as reported in other schedules for the lines shown below:

- Lines 001999999999 through 225099999999 Schedule D, Part 1, Column 1
- Lines 214019999999 through 234509999999 Schedule D, Part 2, Section 1, Column 1
- Lines 245019999999 through 295989999999 Schedule D, Part 2, Section 2, Column 1

The ISIN number should be zero-filled for the following lines:

- Real Estate (Schedule A) ................................................................. 869209999999
- Mortgage Loans on Real Estate (Schedule B) ................................ 879309999999
- Other Invested Assets (Schedule BA) ............................................ 889409999999
- Short-Term Invested Assets (Schedule DA, Part 1) ......................... 889409999999
- Cash (Schedule E, Part 1) ............................................................ 909999999999
- Cash Equivalents (Schedule E, Part 2) ........................................... 919999999999
- Other Assets .................................................................................. 929809999999
## SCHEDULE E – PART 2 – CASH EQUIVALENTS

### INVESTMENTS OWNED END OF CURRENT QUARTER

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<td>All Other Money Market Mutual Funds</td>
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<td>Qualified Cash Pools Under SSAP No. 2R</td>
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<td>Total Cash Equivalents</td>
<td>9099999938609999999</td>
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</table>

A money market fund shall be reported in this schedule as an Exempt Money Market Mutual Fund if such money market fund is identified by the SVO as meeting the required conditions found in Part Six, Section 2(b)(i) of the Purposes and Procedures Manual of the NAIC Investment Analysis Office. All money market mutual funds that are not identified by the SVO on the U.S. Direct Obligations/Full Faith and Credit Exempt List shall be reported in this schedule as an “all other money market mutual fund.”

---

### Column 1 — CUSIP Identification

CUSIP identification is **required and valid only** for Exempt Money Market Mutual Funds – as Identified by SVO (Line 85999999120999999 and All Other Money Market Mutual Funds (Line 8699999938099999999).
**ANNUAL STATEMENT BLANK – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE**

**SUMMARY INVESTMENT SCHEDULE**

<table>
<thead>
<tr>
<th>Investment Categories</th>
<th>Gross Investment Holdings</th>
<th>Admitted Assets as Reported in the Annual Statement</th>
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<td>1.02 All other governments</td>
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<tr>
<td>1.03 U.S. states, territories and possessions, etc. guaranteed</td>
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<td>1.04 U.S. political subdivisions of states, territories, and possessions, guaranteed</td>
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<td>1.05 U.S. special revenue and special assessment obligations, etc. non-guaranteed</td>
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<td>1.06 Industrial and miscellaneous</td>
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<td>2.02 Parent, subsidiaries and affiliates</td>
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<td>2.03 Total preferred stocks</td>
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<td>4.02 Residential mortgages</td>
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<td>4.03 Commercial mortgages</td>
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<td>4.04 Mezzanine real estate loans</td>
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<td>5.02 Properties held for production of income</td>
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<td>5.03 Properties held for sale</td>
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## SCHEDULE D – SUMMARY BY COUNTRY
Long-Term Bonds and Stocks OWNED December 31 of Current Year

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## SCHEDULE D – PART IA – SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

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<th>1 Year or Less</th>
<th>Over 1 Year Through 5 Years</th>
<th>Over 5 Years Through 10 Years</th>
<th>Over 10 Years Through 20 Years</th>
<th>Over 20 Years</th>
<th>No Maturity Date</th>
<th>Total Current Year</th>
<th>Col. 7 as % of Line 6.7</th>
<th>Total from Col. 7 Prior Year</th>
<th>% From Col. 8 Prior Year</th>
<th>Total Publicly Traded</th>
<th>Total Privately Placed</th>
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**Drafting Note:** Remove the “XXX” from Columns 9 and 10 for Lines 11.1 through 11.7 with 2023 reporting.
### SCHEDULE D – PART 1A – SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

<table>
<thead>
<tr>
<th>NAIC Designation</th>
<th>1 Year or Less</th>
<th>Over 1 Year Through 5 Years</th>
<th>Over 5 Years Through 10 Years</th>
<th>Over 10 Years Through 20 Years</th>
<th>Over 20 Years</th>
<th>No Maturity Date</th>
<th>Total Carrying Value</th>
<th>Total as a % of Line 4417</th>
<th>Total from Col. 7</th>
<th>% From Col. 8</th>
<th>No Maturity Date</th>
<th>Total Private</th>
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(a) Includes $ prior year of bonds with Z designations. The letter "Z" means the NAIC designations was not assigned by the Securities Valuation Office (SVO) at the date of the statement.

(b) Includes $ prior year of bonds with Z designations. The letter "Z" means the NAIC designations was not assigned by the Securities Valuation Office (SVO) at the date of the statement.

(c) Includes $ prior year of bonds with Z designations. The letter "Z" means the NAIC designations was not assigned by the Securities Valuation Office (SVO) at the date of the statement.

(d) Includes $ prior year of bonds with Z designations. The letter "Z" means the NAIC designations was not assigned by the Securities Valuation Office (SVO) at the date of the statement.
## SCHEDULE D – PART 1A – SECTION 2

Maturity Distribution of All Bonds Owned December 31, At Book/Adjusted Carrying Values by Major Type and Subtype of Issues

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<td>Total from Col. 7 Prior Year</td>
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<td>% from Col. 8 Prior Year</td>
<td>Total Publicly Traded</td>
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### SCHEDULE D – PART 1A – SECTION 2 (Continued)

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

<table>
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<th>Distribution by Type</th>
<th>1 Year or Less</th>
<th>Over 1 Year Through 5 Years</th>
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<th>Over 10 Years Through 20 Years</th>
<th>Over 20 Years</th>
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<th>Total</th>
<th>% of Line 9</th>
<th>Total from Col. 7</th>
<th>% from Col. 8</th>
<th>Total Publicly Traded</th>
<th>Total Privately Placed</th>
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| 13. Total Bonds Prior Year |                |                             |                               |                                |               |                 |       |             |                  |               |                     |                      |
| 13.01 Issuer Obligations | | | | | | | | | | | | |
| 13.02 Residential Mortgage-Backed Securities | | | | | | | | | | | | |
| 13.03 Commercial Mortgage-Backed Securities | | | | | | | | | | | | |
| 13.04 Other Loan-Backed and Structured Securities | | | | | | | | | | | | |
| 13.05 SVO Identified Funds | | | | | | | | | | | | |
| 13.06 Affiliated Bank Loans | | | | | | | | | | | | |
| 13.07 Unaffiliated Bank Loans | | | | | | | | | | | | |
| 13.08 Line 13.07 as a % Col. 9 | | | | | | | | | | | | |
| 14. Total Publicly Traded Bonds |                |                             |                               |                                |               |                 |       |             |                  |               |                     |                      |
| 14.01 Issuer Obligations | | | | | | | | | | | | |
| 14.02 Residential Mortgage-Backed Securities | | | | | | | | | | | | |
| 14.03 Commercial Mortgage-Backed Securities | | | | | | | | | | | | |
| 14.04 Other Loan-Backed and Structured Securities | | | | | | | | | | | | |
| 14.05 SVO Identified Funds | | | | | | | | | | | | |
| 14.06 Affiliated Bank Loans | | | | | | | | | | | | |
| 14.07 Unaffiliated Bank Loans | | | | | | | | | | | | |
| 14.08 Line 14.07 as a % of Line 14.05 Col. 7 | | | | | | | | | | | | |

| 15. Total Privately Placed Bonds |                |                             |                               |                                |               |                 |       |             |                  |               |                     |                      |
| 15.01 Issuer Obligations | | | | | | | | | | | | |
| 15.02 Residential Mortgage-Backed Securities | | | | | | | | | | | | |
| 15.03 Commercial Mortgage-Backed Securities | | | | | | | | | | | | |
| 15.04 Other Loan-Backed and Structured Securities | | | | | | | | | | | | |
| 15.05 SVO Identified Funds | | | | | | | | | | | | |
| 15.06 Affiliated Bank Loans | | | | | | | | | | | | |
| 15.07 Unaffiliated Bank Loans | | | | | | | | | | | | |
| 15.08 Line 15.07 as a % of Col. 7 | | | | | | | | | | | | |

| 16. Total | | | | | | | | | | | | |
| 17. Treasury Paid-In Interest | | | | | | | | | | | | |
| 18. Line 17.04 as a % Line 17.03 Col. 7 | | | | | | | | | | | | |
### SCHEDULE DA – PART 1
Short-Term Investments

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## NAIC BLANKS (E) WORKING GROUP

### Blanks Agenda Item Submission Form

**DATE:** 11/24/2020  

**CONTACT PERSON:**  

**TELEPHONE:**  

**EMAIL ADDRESS:**  

**ON BEHALF OF:**  

**NAME:** Dale Bruggeman  

**TITLE:** Chair SAPWG  

**AFFILIATION:** Ohio Department of Insurance  

**ADDRESS:** 50W. Town St., 3rd Fl., Ste. 300  

Columbus, OH 43215

### FOR NAIC USE ONLY

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<th>2020-36BWG</th>
<th>Year</th>
<th>2021</th>
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<tbody>
<tr>
<td>Changes to Existing Reporting</td>
<td>[ X ]</td>
<td>New Reporting Requirement</td>
<td>[ ]</td>
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### REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

| No Impact | [ X ] |
| Modsifies Required Disclosure | [ ] |

### DISPOSITION

| Rejected For Public Comment | [ ] |
| Referred To Another NAIC Group | [ ] |
| Received For Public Comment | [ ] |
| Adopted | Date | 03/16/2021 |
| Rejected | Date | |
| Deferred | Date | |
| Other (Specify) | |

### BLANK(S) TO WHICH PROPOSAL APPLIES

| [ X ] ANNUAL STATEMENT | [ X ] INSTRUCTIONS | [ ] CROSSCHECKS |
| [ X ] QUARTERLY STATEMENT | [ ] BLANK |
| [ X ] Life, Accident & Health/Fraternl | [ ] Separate Accounts |
| [ X ] Property/Casualty | [ ] Protected Cell |
| [ X ] Health | [ ] Health (Life Supplement) |

Anticipated Effective Date: Annual 2021

### IDENTIFICATION OF ITEM(S) TO CHANGE

Modify the General Schedules Investment Instructions and Schedule DB General Instructions to reflect treatment of publicly traded stock warrants as being in the scope of SSAP No. 30R—Unaffiliated Common Stock or SSAP No. 32R—Preferred Stock and reporting as common and preferred stock.

### REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to reflect the treatment of publicly traded stock warrants as being in the scope of SSAP No. 30R—Unaffiliated Common Stock or SSAP No. 32R—Preferred Stock from changes to those SSAPs and SSAP No. 86—Derivatives adopted by the Statutory Accounting Principles (E) Working Group (Ref #2020-33).

### NAIC STAFF COMMENTS

Comment on Effective Reporting Date:________________________

Other Comments:________________________________________

** This section must be completed on all forms.  

Revised 7/18/2018

© 2021 National Association of Insurance Commissioners
ANNUAL & QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY & TITLE

INVESTMENT SCHEDULES GENERAL INSTRUCTIONS
(Appplies to all investment schedules)

Detail Eliminated to Conserve Space

General Classifications Preferred Stock Only:

Refer to SSAP No. 32—Preferred Stock and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities for additional guidance.

Industrial and Miscellaneous (Unaffiliated):

All unaffiliated preferred stocks. Include Public Utilities, Banks, Trusts and Insurance Companies. This category includes Exchange Traded Funds included on the “List of Exchange Traded Funds Eligible for Reporting as a Schedule D Preferred Stock” as found on the Securities Valuation Office Web page (https://www.naic.org/svo.htm). Include publicly traded stock warrants captured in the scope of SSAP No. 32R—Preferred Stock.

Parent, Subsidiaries and Affiliates:

Defined by SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities

General Classifications Common Stock Only:

Refer to SSAP No. 30R—Unaffiliated Common Stock and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities.

Industrial and Miscellaneous (Unaffiliated):

All unaffiliated common stocks that are not mutual funds or money market mutual funds. Include Public Utilities, Banks, Trusts and Insurance Companies. Include publicly traded stock warrants captured in the scope of SSAP No. 30R—Unaffiliated Common Stock

Mutual Funds:

All investments in shares of funds regulated as mutual funds by the U.S. Securities and Exchange Commission under the federal Investment Company Act of 1940. This definition does not include unit investments trusts, closed-end funds or hedge funds.

Foreign (non-SEC registered) open-end investment funds governed and authorized in accordance with regulations established by the applicable foreign jurisdiction. Other foreign funds are excluded.

Detail Eliminated to Conserve Space
DEFINITIONS OF DERIVATIVE INSTRUMENTS

A hedge transaction is “Anticipatory” if it relates to:

a. A firm commitment to purchase assets or incur liabilities; or
b. An expectation (but not obligation) to purchase assets or incur liabilities in the normal course of business.

“Underlying Interest” means the asset(s), liability(ies) or other interest(s) underlying a derivative instrument, including, but not limited to, any one or more securities, currencies, rates, indices, commodities, derivative instruments, or other financial market instruments.

“Option” means an agreement giving the buyer the right to buy or receive, sell or deliver, enter into, extend or terminate, or effect a cash settlement based on the actual or expected price, level, performance or value of one or more Underlying Interests.

“Warrant” means an agreement that gives the holder the right to purchase an underlying financial instrument at a given price and time or at a series of prices and times according to a schedule or warrant agreement. Exclude publicly traded stock warrants are captured in scope of SSAP No. 30R—Unaffiliated Common Stock or SSAP No. 32R—Preferred Stock.

“Cap” means an agreement obligating the seller to make payments to the buyer, each payment under which is based on the amount, if any, that a reference price, level, performance or value of one or more Underlying Interests exceed a predetermined number, sometimes called the strike/cap rate or price.

GENERAL INSTRUCTIONS FOR SCHEDULE DB

Each derivative instrument should be reported in Parts A, B or C according to the nature of the instrument, as follows:

Part A: Positions in Options*, Caps, Floors, Collars, Swaps, and Forwards**
Part B: Positions in Futures Contracts
Part C: Positions in Replication (Synthetic Asset) Transaction

* Warrants acquired in conjunction with public or private debt or equity that are more appropriately reported in other schedules do not have to be reported in Schedule DB. Excludes publicly traded stock warrants captured in the scope of SSAP No. 30R—Unaffiliated Common Stock or SSAP No. 32R—Preferred Stock.

** Forward commitments that are not derivative instruments (for example, the commitment to purchase a GNMA security two months after the commitment date or a private placement six months after the commitment date) should be disclosed in the Notes to Financial Statements, rather than on Schedule DB.
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY & TITLE

SCHEDULE D – PART 2 – SECTION 1

PREFERRED STOCKS OWNED DECEMBER 31 OF CURRENT YEAR

Detail Eliminated to Conserve Space

Column 8 – Book/Adjusted Carrying Value

The chart below details the appropriate valuation method for this column. The *Purposes & Procedures Manual of the NAIC Investment Analysis Office* and *SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities* may allow other valuation methods for preferred stock investments in Subsidiary, Controlled or Affiliated (SCA) companies.

Deduct: Cash dividends paid on Payment In Kind stock during the stock dividend period.

A direct write-down for a decline in the fair value of a stock that is other-than-temporary.

For reporting entities maintaining an AVR:

Redeemable Preferred
- NAIC Designation 1 – 3 Enter book value.
- NAIC Designation 4 – 6 Enter the lower of book value or fair value.

Perpetual Preferred
- NAIC Designation 1 – 3 Enter book value.
- NAIC Designation 4 – 6 Enter the lower of book value or fair value.

For reporting entities not maintaining an AVR:

Redeemable Preferred
- NAIC Designation 1 – 2 Enter book value.
- NAIC Designation 3 – 6 Enter the lower of book value or fair value.

Perpetual Preferred
- NAIC Designations 1 – 2 Enter fair value.
- NAIC Designations 3 – 6 Enter the lower of book value or fair value.

The amount reported in this column should equal:

- Book/Adjusted Carrying Value reported in the Prior Year statement (or Actual Cost for newly acquired securities)
- plus “Total Change in Book/Adjusted Carrying Value”
- plus “Total Foreign Exchange Change in Book/Adjusted Carrying Value”
- plus Changes due to amounts reported in Schedule D, Parts 3, 4 and 5

Report publicly traded stock warrants captured in the scope of *SSAP No. 32R—Preferred Stock at Fair Value*.

Detail Eliminated to Conserve Space
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

DATE: 11/30/2020

CONTACT PERSON: _____________________________________________

TELEPHONE: _____________________________________________

EMAIL ADDRESS: _____________________________________________

ON BEHALF OF: _____________________________________________

NAME: Dale Bruggeman

TITLE: Chair SAPWG

AFFILIATION: Ohio Department of Insurance

ADDRESS: 50W. Town St., 3rd FL, Ste. 300 Columbus, OH 43215

FOR NAIC USE ONLY

Agenda Item #: 2020-37BWG MOD

Year: 2021

Changes to Existing Reporting [ X ]

New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [ X ]

Modifies Required Disclosure [ ]

DISPOSITION

[ ] Rejected For Public Comment

[ ] Referred To Another NAIC Group

[ ] Received For Public Comment

[ X ] Adopted Date 03/16/2021

[ ] Rejected Date

[ ] Deferred Date

[ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT

[ X ] QUARTERLY STATEMENT

[ X ] Life, Accident & Health/Fraternal

[ X ] Property/Casualty

[ X ] Health

[ X ] Separate Accounts

[ ] Protected Cell

[ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2021

IDENTIFICATION OF ITEM(S) TO CHANGE

Add a new Schedule Y, Part 3 to capture all entities with ownership greater than 10%, the ultimate controlling parties of those owners and other entities that the ultimate controlling party controls.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to reflect disclosure changes adopted by the Statutory Accounting Principles (E) Working Group for SSAP No. 25—Affiliates and Other Related Parties (Ref #2019-34) regarding disclosure of owner(s), its ultimate controlling party and other entities the ultimate controlling party controls.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

** This section must be completed on all forms.

Attachment Two-G

Accounting Practices and Procedures (E) Task Force

3/23/21

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ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SCHEDULE Y


All insurer and reporting entity members of the holding company system shall prepare a common schedule for inclusion in each of the individual annual statements.

<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Insurers in Holding Company</td>
</tr>
<tr>
<td></td>
<td>Report all insurers in the holding company that file with the NAIC.</td>
</tr>
<tr>
<td>2</td>
<td>Owners with Greater Than 10% Ownership</td>
</tr>
<tr>
<td></td>
<td>Provide the name of all owners of the insurers reported in Column 1 with an ownership percentage greater than 10%.</td>
</tr>
<tr>
<td>3</td>
<td>Ownership Percentage Column 2 of Column 1</td>
</tr>
<tr>
<td></td>
<td>Provide the ownership percentage of the entity reported in Column 2 of the insurer reported in Column 1.</td>
</tr>
<tr>
<td>4</td>
<td>Granted Disclaimer of Control/Affiliation of Column 2 Over Column 1 (Yes/No)</td>
</tr>
<tr>
<td></td>
<td>Indicate if the entity reported in Column 2 as owner of the entity reported in Column 1 was granted a disclaimer of control or affiliation by the state of domicile.</td>
</tr>
<tr>
<td>5</td>
<td>Ultimate Controlling Party</td>
</tr>
<tr>
<td></td>
<td>Provide the name of all U.S. insurance groups (which is consistent with the “Group Name” on Schedule Y—Part 1A) controlled by the ultimate controlling party of the entity reported in Column 2. If an entity reported in Column 5 is not part of an insurance group, provide the name of the individual insurance entity. Within Schedule Y, the terms “Ultimate Controlling Party” and “Ultimate Controlling Entity(ies)/Person(s)” are used interchangeably.</td>
</tr>
<tr>
<td>6</td>
<td>U.S. Insurance Groups or Entities Controlled by Column 5</td>
</tr>
<tr>
<td></td>
<td>Provide the names of all U.S. insurance groups or entities controlled by the entity reported in Column 5.</td>
</tr>
<tr>
<td>7</td>
<td>Ownership Percentage Column 5 of Column 6</td>
</tr>
<tr>
<td></td>
<td>Provide the ownership percentage of the ultimate controlling party reported in Column 5 of the entity reported in Column 6.</td>
</tr>
<tr>
<td>8</td>
<td>Granted Disclaimer of Control/Affiliation of Column 5 Over Column 6 (Yes/No)</td>
</tr>
<tr>
<td></td>
<td>Indicate if the entity reported in Column 5 as the ultimate controlling party of the entity reported in Column 6 was granted a disclaimer of control or affiliation by the state of domicile.</td>
</tr>
</tbody>
</table>
### SCHEDULE


<table>
<thead>
<tr>
<th>Column 1</th>
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<th>Column 4</th>
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<td>Column 9</td>
<td>Column 10</td>
<td>Column 11</td>
<td>Column 12</td>
</tr>
<tr>
<td>Column 13</td>
<td>Column 14</td>
<td>Column 15</td>
<td>Column 16</td>
<td>Column 17</td>
<td>Column 18</td>
</tr>
<tr>
<td>Group with Common Than One Controlling Party</td>
<td>Group with Common Than One Controlling Party</td>
<td>Group with Common Than One Controlling Party</td>
<td>Group with Common Than One Controlling Party</td>
<td>Group with Common Than One Controlling Party</td>
<td>Group with Common Than One Controlling Party</td>
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</tbody>
</table>
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>Jacob W. Garn</th>
</tr>
</thead>
<tbody>
<tr>
<td>TITLE:</td>
<td>Chair, Blanks Working Group</td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td></td>
</tr>
<tr>
<td>ADDRESS:</td>
<td></td>
</tr>
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</table>

DATE: 11/30/2020

FOR NAIC USE ONLY

<table>
<thead>
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<th>Agenda Item #</th>
<th>2020-38BWG MOD</th>
</tr>
</thead>
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<tr>
<td>Year</td>
<td>2021</td>
</tr>
<tr>
<td>Changes to Existing Reporting</td>
<td>X</td>
</tr>
<tr>
<td>New Reporting Requirement</td>
<td></td>
</tr>
<tr>
<td>REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</td>
<td></td>
</tr>
<tr>
<td>No Impact</td>
<td>X</td>
</tr>
<tr>
<td>Modifies Required Disclosure</td>
<td></td>
</tr>
<tr>
<td>DISPOSITION</td>
<td></td>
</tr>
<tr>
<td>[ ] Rejected For Public Comment</td>
<td></td>
</tr>
<tr>
<td>[ ] Referred To Another NAIC Group</td>
<td></td>
</tr>
<tr>
<td>[ ] Received For Public Comment</td>
<td></td>
</tr>
<tr>
<td>[ X ] Adopted Date 03/16/2021</td>
<td></td>
</tr>
<tr>
<td>[ ] Rejected Date</td>
<td></td>
</tr>
<tr>
<td>[ ] Deferred Date</td>
<td></td>
</tr>
<tr>
<td>[ ] Other (Specify)</td>
<td></td>
</tr>
</tbody>
</table>

BLANK(S) TO WHICH PROPOSAL APPLIES

- [ X ] ANNUAL STATEMENT
- [ X ] INSTRUCTIONS
- [ X ] CROSSCHECKS
- [ ] QUARTERLY STATEMENT
- [ X ] BLANK
- [ X ] Life, Accident & Health/Fraternal
- [ X ] Property/Casualty
- [ X ] Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2021 except state level detailed which will be effective Annual 2022

IDENTIFICATION OF ITEM(S) TO CHANGE

Make changes to the Accident and Health Policy Experience Exhibit by adding new columns, removing lines distinguishing with and without contract reserves, add some new product lines, eliminate summary tables, change the date that the exhibit is due and have it reported by state. See next page for details.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of the proposal is to provide regulators additional health data and greater consistency across the blanks. The proposal also gives state level detail which has been asked for in the past.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

** This section must be completed on all forms. Revised 7/18/2018

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Attachment Two-H

Accounting Practices and Procedures (E) Task Force

3/23/21

NAIC Proceedings – Spring 2021

10-465
IDENTIFICATION OF ITEM(S) TO CHANGE

Make the following modifications to the Accident and Health Policy Experience Exhibit:

- Remove lines reporting individual business by “With Contract Reserves” and “Without Contract Reserves”. Report just the total of those lines.

- Add additional Columns to the Exhibit.
  - Direct Premiums Written
  - Assumed Premiums Earned
  - Ceded Premiums Earned
  - Net Premiums Earned
  - Assumed Incurred Claims Amount
  - Ceded Incurred Claims Amount
  - Net Incurred Claims Amount

- Split reporting of Short-Term Medical into “6 Months or Less” and “Over 6 Months”

- Add line for “Vision” in the group and individual sections

- Eliminate the summary tables (Parts 1 through 4) as reinsurance information captures in the main exhibit

- Report Exhibit by State

- Change due date of exhibit from April 1 to March 1

- Make the instructions uniform so just one set of instructions needs to be maintained
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

ACCIDENT AND HEALTH POLICY EXPERIENCE EXHIBIT

This exhibit is required to be filed no later than April 1.

A schedule must be prepared and submitted to the state of domicile for each jurisdiction in which the company has Written Premium (Direct), Earned Premium (Direct, Assumed and Ceded) or Incurred Claims (Direct, Assumed and Ceded). In addition, a schedule must be prepared and submitted that contains the grand total (GT) for the company.

1. The name of the company must be clearly shown at the top of each page or pages.

2. The Exhibit will show information concerning direct business written on policy forms approved for use in the United States with a final total for all policy forms (including non-U.S. policy forms) on the bottom line of the Exhibit.

The Exhibit will show information for each listed product for Individual, Group, and Other business categories. Subtotals by product within the individual category are required for all columns.

3. A Summary Page shows a reconciliation with Schedule H for Individual, Group and Credit policies separately and in total for companies filing the Life, Accident and Health Companies/Fraternal Benefit Societies and Property/Casualty Annual Statement, and a reconciliation of these policies in total only with the specified exhibits of the Health Annual Statement for companies filing that statement.

4. This Exhibit should not include any data pertaining to double indemnity, waiver of premiums and other disability benefits embodied in life contracts.

5. Include membership charges, modal loadings, and policy fees, if any, with premiums earned (Column 1).

DEFINITIONS

Accident Only or AD&D

Policies that provide coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accidents. Types of coverage include student accident, sports accident, travel accident, blanket accident, specific accident or accidental death and dismemberment (AD&D).

Credit

Individual or group policies that provide benefits to a debtor for full or partial repayment of debt associated with a specific loan or other credit transaction upon disability or involuntary unemployment of debtor, except in connection with first mortgage loans. In some states, involuntary unemployment credit insurance is not included in health insurance. This category should not include that type of credit insurance in those states.

Dental

Policies providing only coverage (dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw) issued as stand-alone dental or as a rider to a medical policy that is not related to the medical policy through premiums, deductibles or out-of-pocket limits. If dental benefits are part of a comprehensive medical plan, then include data under comprehensive/major medical category. Does not include self-insured business, as well as federal employee’s health benefits plans (FEHBP), or Medicare and Medicaid programs.
Disability Income – Long-Term

Policies that provide a weekly or monthly income benefit for more than five years for individual coverage and more than one year for group coverage for full or partial disability arising from accident and/or sickness. Include policies that provide Overhead Expense Benefits. Does not include credit disability.

TRICARE

Policies issued in association with the Department of Defense’s health care program for active-duty military, active-duty service families, retirees and their families, and other beneficiaries.

CROSS REFERENCES AND OTHER INSTRUCTIONS

The Exhibit

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Direct Premiums Written</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The grand total reported should equal:</td>
</tr>
<tr>
<td>Life/Fraternal</td>
<td>Exhibit 1, Part 1, Lines (6.1+10.1+16.1), Columns (8+9+10).</td>
</tr>
<tr>
<td>Health</td>
<td>Underwriting and Investment Exhibit, Part 1, Line 9, Column 1.</td>
</tr>
<tr>
<td>Property</td>
<td>Exhibit of Premiums and Losses, Column 1 sum of Lines 13 through 15.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 12</th>
<th>Direct Premiums Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fractional premium loadings and policy fees must be included in the Earned Premiums.</td>
<td></td>
</tr>
</tbody>
</table>

The Policy Experience Exhibit requires that the Premiums Earned should be on a direct basis such that the grand total reported should equal:

| Life/Fraternal | Exhibit 1, Part 1, Lines (6.1+10.1+16.1), Columns (8+9+10). |
|               | Plus Exhibit 1, Part 1, Lines (3.1+13.1), Columns (8+9+10). |
|               | Minus Exhibit 6, Line 1, Column 1 CY. |
|               | Plus Exhibit 6, Line 1, Column 1 PY. |
|               | Minus Exhibit 1, Part 1, Lines (4+14), Columns (8+9+10). |
|               | Minus Exhibit 6, Line 5, Column 1 CY. |
|               | Plus Exhibit 6, Line 5, Column 1 PY. |

| Health | Underwriting and Investment Exhibit, Part 1, Line 9, Column 1 |
|        | Less Underwriting and Investment Exhibit Part 2D, Line 1, Column 1 CY |
|        | Less Underwriting and Investment Exhibit Part 2D, Line 4, Column 1 CY |
|        | Plus Underwriting and Investment Exhibit Part 2D, Line 1, Column 1 PY |
|        | Plus Underwriting and Investment Exhibit Part 2D, Line 4, Column 1 PY |

| Property | Exhibit of Premiums and Losses, Column 2 sum of Lines 13 through 15. |
A. Premiums Collected During the Year

   Exhibit 1, Part 1, Lines (6.1+10.1+16.1), Columns (8+9+10).

B. Plus the Change in Deferred and Uncollected

   Exhibit 1, Part 1, Lines (3.1+13.1), Columns (8+9+10).

C. Minus the Increase in Premium Reserves on Direct Business Only Included in:

   1. Unearned Premium Reserve

      Exhibit 6, Line 1, Column 1.

   2. Advance Premiums

      Exhibit 1, Part 1, Lines (4+14), Columns (8+9+10).

   3. Reserves for Rate Credits

      Exhibit 6, Line 5, Column 1.

The grand total reported should equal:

Property Schedule H, Part 1, Column 1, Line 2

Column 26 – Direct Incurred Claims Amount

This column does not include the “Increase in Policy Reserves.”

The Policy Experience Exhibit requires that the Incurred Claims should be on a direct basis such that the grand total reported should equal:

Life/Fratal

   Exhibit 8, Part 2, Line 6.1, Columns (9+10+11).

   Plus Exhibit 6, Line 14, Column 1.

Health

   Underwriting and Investment Exhibit, Part 2, Line 12.1, Column 1 minus Column 10.

   NOTE: This excludes payments for any administrative costs.

Property

   Exhibit of Premiums and Losses, Column 6 sum of Lines 13 through 15.

A. Incurred Claims

   Exhibit 8, Part 2, Line 6.1, Columns (9+10+11).

B. Plus the Change in Claim Reserves on Direct Business Only Included in:

   Exhibit 6, Line 14, Column 1.
### Column 7 – Assumed Incurred Claims Amount

The grand total reported should equal:

| Health | Underwriting and Investment Exhibit, Part 2, Line 12.2, Column 1 minus Column 10. |
| Property | Underwriting and Investment Exhibit, Part 2, Column 2 sum of Lines 13 through 15. |
| Plus | Underwriting and Investment Exhibit, Part 2A, Column 2 sum of Lines 13 through 15 – Current Year. |
| Minus | Underwriting and Investment Exhibit, Part 2A, Column 2 sum of Lines 13 through 15 – Prior Year. |
| Plus | Underwriting and Investment Exhibit, Part 2A, Column 6 sum of Lines 13 through 15 – Current Year. |
| Minus | Underwriting and Investment Exhibit, Part 2A, Column 6 sum of Lines 13 through 15 – Prior Year. |

### Column 8 – Ceded Incurred Claims Amount

The grand total reported should equal:

| Health | Underwriting and Investment Exhibit, Part 2, Line 12.3, Column 1 minus Column 10. |
| Property | Underwriting and Investment Exhibit, Part 2, Column 3 sum of Lines 13 through 15. |
| Plus | Underwriting and Investment Exhibit, Part 2A, Column 3 sum of Lines 13 through 15 – Current Year. |
| Minus | Underwriting and Investment Exhibit, Part 2A, Column 3 sum of Lines 13 through 15 – Prior Year. |
| Plus | Underwriting and Investment Exhibit, Part 2A, Column 7 sum of Lines 13 through 15 – Current Year. |
| Minus | Underwriting and Investment Exhibit, Part 2A, Column 7 sum of Lines 13 through 15 – Prior Year. |

### Column 9 – Net Incurred Claims Amount

The grand total reported should equal:

| Life\Fraternal | Schedule H, Part 1, Column 1, Line 3 |
| Health | Underwriting and Investment Exhibit, Part 2, Line 12.4, Column 1 minus Column 10. |
| Property | Schedule H, Part 1, Column 1, Line 3 |

### Column 310 – Change in Contract Reserves

The Policy Experience Exhibit requires that the change in contract reserves should be on a direct basis. This is the direct basis included in the sum of:

Line 2, Grand Total Individual, Group and Other Business of “D” Total Business should equal:

A. The Change in Additional Reserves

     Life\Fraternal: Exhibit 6, Lines 2 + 3, Column 1. Current year minus prior year.
B. Plus the Change in the Reserve for Future Contingent Benefits


C. Less the Change in the Premium Deficiency Reserve

Life/Fraternal and Property: Footnote (a) Schedule H Part 2. Current year minus prior year.

Health: Footnote (a) Underwriting and Investment Exhibit Part 2D. Current year minus prior year.

Column 411 – Loss Ratio

This is the ratio of the Direct Incurred Claims (Column 26) plus the Change in Contract Reserves (Column 310) to Direct Premiums Earned (Column 12).

Column 512 – Number of Policies or Certificates as of Dec. 31

This is the number of individual policies or group certificates issued to individuals covered under a group policy in force as of Dec. 31 of the reporting year. It is not the number of persons covered under individual policies or group certificates. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity. For Administrative Services Only or Administrative Services Contracts, include the number of persons covered. See SSAP No. 47—Uninsured Plans.

Column 613 – Number of Covered Lives

This is the total number of lives insured, including dependents, under individual policies and group certificates as of Dec. 31 of the reporting year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity. For Administrative Services Only or Administrative Services Contracts, include the number of lives covered. See SSAP No. 47—Uninsured Plans.

Column 714 – Member Months

The sum of total number of lives insured on a pre-specified day of each month of the reported year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity. For Administrative Services Only or Administrative Services Contracts, include the number of lives covered for each month of the reported year. See SSAP No. 47—Uninsured Plans.
Part 1

Columns 1 and 2 should agree to Schedule H – Part 1, Column 1 minus the sum of Columns 3 and 5, Lines 2 and 3, respectively.

Part 2

Columns 1 and 2 should agree to Schedule H – Part 1, Column 3, Lines 2 and 3, respectively.

Not applicable to Fraternal Benefit Societies.

Part 3

Columns 1 and 2 should agree to Schedule H – Part 1, Column 5, Lines 2 and 3, respectively.

Not applicable to Fraternal Benefit Societies.

Part 4

Columns 1 and 2 should agree to Schedule H – Part 1, Column 1, Lines 2 and 3, respectively. Column 3 should agree to Schedule H – Part 1 Line 6 less the change in premium deficiency reserve Footnote (a) Schedule H Part 2 current year minus prior year.

Not applicable to Fraternal Benefit Societies.
LINES OF BUSINESS – LIFE, ANNUITIES AND ACCIDENT AND HEALTH

DEFINITIONS OF LINES OF BUSINESS – LIFE

DEFINITIONS SPECIFICALLY RELATED TO ACCIDENT AND HEALTH

Riders/Endorsements/Floaters:

If a rider, endorsement or floater acts like a separate policy with separate premium, deductible and limit, then it is to be recorded on the same line of business as if it were a stand-alone policy regardless of whether it is referred to as a rider, endorsement or floater. If there is no additional premium, separate deductible or limit, the rider, endorsement or floater should be reported on the same line of business as the base policy.

Comprehensive (Hospital and Medical):

Business that provides for medical coverage including hospital, surgical, and major medical. Includes State Children’s Health Insurance Program (SCHIP) Medicaid Program (Title XXI) risk contracts. Also includes medical only programs that provide medical only benefits without hospital coverage. Does not include self-insured business as well as federal employees health benefit programs (FEHBP), Medicare and Medicaid programs, dental only business, indemnity and limited benefit plans that are included in Other Health.

Medicare Supplement:

Business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statements. Does not include Medicare (Title XVIII) or Medicaid (Title XIX) risk contracts.

Dental-Only:

Policies providing for dental only coverage (dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw) issued as stand-alone dental or as a rider to a medical policy that is not related to the medical policy through premiums, deductibles or out-of-pocket limits. If dental benefits are part of a comprehensive medical plan, then include data under comprehensive/major medical category. Does not include self-insured business, as well as federal employees health benefits plans (FEHBP), or Medicare and Medicaid programs.

Vision-Only:

Policies providing for vision only coverage issued as stand-alone vision or as a rider to a medical policy that is not related to the medical policy through premiums, deductibles or out-of-pocket limits. Does not include self-insured business, federal employees health benefit plans (FEHBP), or Medicare and Medicaid programs.
ANNUAL STATEMENT INSTRUCTIONS – HEALTH

ACCIDENT AND HEALTH POLICY EXPERIENCE EXHIBIT

This exhibit is required to be filed no later than March 1.

A schedule must be prepared and submitted to the state of domicile for each jurisdiction in which the company has written Premium (Direct), Earned Premium (Direct, Assumed and Ceded) or Incurred Claims (Direct, Assumed and Ceded). In addition, a schedule must be prepared and submitted that contains the grand total (GT) for the company.

1. The name of the company must be clearly shown at the top of each page or pages.

2. The Exhibit will show information concerning direct business written on policy forms approved for use in the United States with a final total for all policy forms (including non-U.S. policy forms) on the bottom line of the Exhibit.

The Exhibit will show information for each listed product for Individual, Group, and Other business categories. Subtotals by product within the individual category are required for all columns.

3. A Summary Page shows a reconciliation with Schedule H for Individual, Group and Credit policies separately and in total for companies filing the Life, Accident and Health Companies/Fraternal Benefit Societies and Property/Casualty Annual Statement, and a reconciliation of these policies in total only with the specified exhibits of the Health Annual Statement for companies filing that statement.

4. This Exhibit should not include any data pertaining to double indemnity, waiver of premiums and other disability benefits embodied in life contracts.

5. Include membership charges, modal loadings, and policy fees, if any, with premiums earned (Column 1).

DEFINITIONS

Accident Only or AD&D

Policies that provide coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accidents. Types of coverage include student accident, sports accident, travel accident, blanket accident, specific accident or accidental death and dismemberment (AD&D).

Administrative Services Only (ASO) and Administrative Services Contract (ASC)

An uninsured accident and health plan is where an administrator performs administrative services for a third party that is at risk, but has not issued an insurance policy. The health plan bears all of the insurance risk, and there is no possibility of loss or liability to the administrator caused by claims incurred related to the plan. Under an ASO plan, claims are paid from a bank account owned and funded directly by the uninsured plan sponsor; or, claims are paid from a bank account owned by the administrator, but only after receiving funds from the plan sponsor that are adequate to fully cover the claim payments. Under an ASC plan, the administrator pays claims from its own bank accounts, and only subsequently receives reimbursement from the plan sponsor.

Comprehensive/Major Medical

Policies that provide fully insured indemnity, HMO, PPO or Fee for Service coverage for hospital, medical, and surgical expenses. This category excludes Short Term Medical Insurance, the Federal Employees Health Benefit Program and non-comprehensive coverage such as basic hospital only, medical only, hospital confinement indemnity, surgical, outpatient indemnity, specified disease, intensive care, and organ and tissue transplant coverage as well as any other coverage described in the other categories of this exhibit.
Group business is further segmented under this category as follows (please note there is a separate category for Administrative Services Only/Administrative Services Contract business):

**Single Employer:**
Group policies issued to one employer for the benefit of its employees. This would include affiliated companies that have common ownership.

**Small Employer:** Group policies issued to single employers that are subject to the definition of Small Employer business, when so defined, in the group’s state of situs.

**Other Employer:** Group policies issued to single employers that are not defined as Small Employer business.

**Multiple Employer Associations and Trusts:**
Group policies that are issued to an association or to a trust. This category also includes policies issued to one or more trustees of a fund established or adopted by two or more employers, or by one or more labor unions or similar employee organizations. The organizations include those that are exempt and also those that are non-exempt from statewide community rating. This category does not exclude policies providing coverage to employees of small employers, as defined in the employer’s state of situs.

**Other Associations and Discretionary Trusts:**
Trusts: Group policies issued to associations and trusts that are not included in the Small Employer, Other Employer or Multiple Employer Associations and Trusts group categories. This category does not exclude insurance providing coverage to employees of small employers, as defined in the employer’s state of situs. This category does include blanket and franchise accident and sickness insurance, and insurance for any group that includes members other than employees, such as an association that has both employees of participating employers and also individuals as members.

**Other Comprehensive/Major Medical:**
Group policies providing comprehensive or major medical benefits that are not included in any of the categories listed above.

**Contract Reserves**
Reserves set up when, due to the gross premium structure, the future benefits exceed the future net premium. Contract reserves are in addition to claim and premium reserves.

**Credit**
Individual or group policies that provide benefits to a debtor for full or partial repayment of debt associated with a specific loan or other credit transaction upon disability or involuntary unemployment of debtor, except in connection with first mortgage loans. In some states, involuntary unemployment credit insurance is not included in health insurance. This category should not include that type of credit insurance in those states.

**Dental**
Policies providing for dental only coverage (dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw) issued as stand-alone dental or as a rider to a medical policy that is not related to the medical policy through premiums, deductibles or out-of-pocket limits. If dental benefits are part of a comprehensive medical plan, then include data under comprehensive/major medical category. Does not include self-insured business, as well as federal employee’s health benefits plans (FEHBP), or Medicare and Medicaid programs.
Disability Income – Long-Term

Policies that provide a weekly or monthly income benefit for more than five years for individual coverage and more than one year for group coverage for full or partial disability arising from accident and/or sickness. Include policies that provide Overhead Expense Benefits. Does not include credit disability.

TRICARE

Policies issued in association with the Department of Defense’s health care program for active-duty military, active-duty service families, retirees and their families, and other beneficiaries.

CROSS REFERENCES AND OTHER INSTRUCTIONS

The Exhibit

Column 1 – Direct Premiums Written

<table>
<thead>
<tr>
<th>The grand total reported should equal:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life\Fraternal</td>
</tr>
<tr>
<td>Health</td>
</tr>
<tr>
<td>Property</td>
</tr>
</tbody>
</table>

Column 12 – Direct Premiums Earned

Fractional premium loadings and policy fees must be included in the Earned Premiums.

The Policy Experience Exhibit requires that the Premiums Earned should be on a direct basis such that the grand total reported should equal:

| Life\Fraternal | Exhibit 1, Part 1, Lines (6.1+10.1+16.1), Columns (8+9+10). |
| Plus | Exhibit 1, Part 1, Lines (3.1+13.1), Columns (8+9+10). |
| Minus | Exhibit 6, Line 1, Column 1 CY. |
| Plus | Exhibit 6, Line 1, Column 1 PY. |
| Minus | Exhibit 1, Part 1, Lines (4+14), Columns (8+9+10). |
| Minus | Exhibit 6, Line 5, Column 1 CY. |
| Plus | Exhibit 6, Line 5, Column 1 PY. |

| Health | Underwriting and Investment Exhibit, Part 1, Line 9, Column 1 |
| Less | Underwriting and Investment Exhibit Part 2D, Line 1, Column 1 CY. |
| Plus | Underwriting and Investment Exhibit Part 2D, Line 1, Column 1 PY. |
| Less | Underwriting and Investment Exhibit Part 2D, Line 4, Column 1 CY. |
| Plus | Underwriting and Investment Exhibit Part 2D, Line 4, Column 1 PY. |

| Property | Exhibit of Premiums and Losses, Column 2 sum of Lines 13 through 15. |
A. **Premiums Written During the Year**

Underwriting and Investment Exhibit, Part 1, Line 9, Column 1.

B. Minus the Increase in Premium Reserves on Direct Business Only Included in:

1. **Unearned Premium Reserve**

   Underwriting and Investment Exhibit Part 2D, Line 1, Column 1.

2. **Reserves for Rate Credits or Experience Rating Refunds**

   Underwriting and Investment Exhibit Part 2D, Line 4, Column 1.

<table>
<thead>
<tr>
<th>Column 5</th>
<th>–</th>
<th>Net Premiums Earned</th>
</tr>
</thead>
</table>

The grand total reported should equal:

Property Schedule H, Part 1, Column 1, Line 2

<table>
<thead>
<tr>
<th>Column 26</th>
<th>–</th>
<th>Direct Incurred Claims Amount</th>
</tr>
</thead>
</table>

This column does not include the “Increase in Policy Reserves.”

The **Policy Experience Exhibit** requires that the **Incurred Claims** should be on a direct basis such that the grand total reported should equal:

- **Life\Fraternal**
  - Exhibit 8, Part 2, Line 6.1, Columns (9+10+11).
  - Plus Exhibit 6, Line 14, Column 1.

- **Health**
  - Underwriting and Investment Exhibit, Part 2, Line 12.1, Column 1 minus Column 10.
  - NOTE: This excludes payments for any administrative costs.

- **Property**
  - Exhibit of Premiums and Losses, Column 6 sum of Lines 13 through 15.

A. **Incurred Claims**

Underwriting and Investment Exhibit, Part 2, Line 12.1, Column 1 minus Column 10.

NOTE: This excludes payments for any administrative costs.

<table>
<thead>
<tr>
<th>Column 7</th>
<th>–</th>
<th>Assumed Incurred Claims Amount</th>
</tr>
</thead>
</table>

The grand total reported should equal:

- **Health**
  - Underwriting and Investment Exhibit, Part 2, Line 12.2, Column 1 minus Column 10.

- **Property**
  - Underwriting and Investment Exhibit, Part 2, Column 2 sum of Lines 13 through 15.
  - Plus Underwriting and Investment Exhibit, Part 2A, Column 2 sum of Lines 13 through 15 – Current Year.
  - Minus Underwriting and Investment Exhibit, Part 2A, Column 2 sum of Lines 13 through 15 – Prior Year.
  - Plus Underwriting and Investment Exhibit, Part 2A, Column 6 sum of Lines 13 through 15 – Current Year.
### Column 8 – Ceded Incurred Claims Amount

The grand total reported should equal:

<table>
<thead>
<tr>
<th>Category</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>Underwriting and Investment Exhibit, Part 2, Line 12.3, Column 1 minus Column 10.</td>
</tr>
<tr>
<td>Property</td>
<td>Underwriting and Investment Exhibit, Part 2, Column 3 sum of Lines 13 through 15.</td>
</tr>
<tr>
<td></td>
<td>Plus Underwriting and Investment Exhibit, Part 2A, Column 3 sum of Lines 13 through 15 – Current Year.</td>
</tr>
<tr>
<td></td>
<td>Minus Underwriting and Investment Exhibit, Part 2A, Column 3 sum of Lines 13 through 15 – Prior Year.</td>
</tr>
<tr>
<td></td>
<td>Plus Underwriting and Investment Exhibit, Part 2A, Column 7 sum of Lines 13 through 15 – Current Year.</td>
</tr>
<tr>
<td></td>
<td>Minus Underwriting and Investment Exhibit, Part 2A, Column 7 sum of Lines 13 through 15 – Prior Year.</td>
</tr>
</tbody>
</table>

### Column 9 – Net Incurred Claims Amount

The grand total reported should equal:

<table>
<thead>
<tr>
<th>Category</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life\Fraternal</td>
<td>Schedule H, Part 1, Column 1, Line 3</td>
</tr>
<tr>
<td>Health</td>
<td>Underwriting and Investment Exhibit, Part 2, Line 12.4, Column 1 minus Column 10.</td>
</tr>
<tr>
<td>Property</td>
<td>Schedule H, Part 1, Column 1, Line 3</td>
</tr>
</tbody>
</table>

### Column 310 – Change in Contract Reserves

The Policy Experience Exhibit requires that the change in contract reserves should be on a direct basis. This is the direct basis included in the sum of:

Line 2, Grand Total Individual, Group and Other Business of “D” Total Business should equal:

A. The Change in Additional Reserves

   - **Life\Fraternal:** Exhibit 6, Lines 2 + 3, Column 1. Current year minus prior year.
   - **Health:** Underwriting and Investment Exhibit, Part 2D, Line 2, Column 1. Current year minus prior year.

B. Plus the Change in the Reserve for Future Contingent Benefits

   - **Life\Fraternal:** Exhibit 6, Line 4, Column 1. Current year minus prior year.
   - **Health:** Underwriting and Investment Exhibit, Part 2D, Line 3, Column 1. Current year minus prior year.

C. Less the Change in the Premium Deficiency Reserve

   - **Life\Fraternal and Property:** Footnote (a) Schedule H Part 2. Current year minus prior year.
Footnote (a) Underwriting and Investment Exhibit Part 2D. Current year minus prior year.

Column 411 – Loss Ratio

This is the ratio of the Direct Incurred Claims (Column 26) plus the Change in Contract Reserves (Column 310) to Direct Premiums Earned Premiums (Column 12).

Column 512 – Number of Policies or Certificates as of Dec. 31

This is the number of individual policies or group certificates issued to individuals covered under a group policy in force as of Dec. 31 of the reporting year. It is not the number of persons covered under individual policies or group certificates. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity. For Administrative Services Only or Administrative Services Contracts, include number of persons covered. See SSAP No. 47—Uninsured Plans.

Column 613 – Number of Covered Lives

This is the total number of lives insured, including dependents, under individual policies and group certificates as of Dec. 31 of the reporting year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity. For Administrative Services Only or Administrative Services Contracts, include number of lives covered. See SSAP No. 47—Uninsured Plans.

Column 714 – Member Months

The sum of total number of lives insured on a pre-specified day of each month of the reported year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity. For Administrative Services Only or Administrative Services Contracts, include number of lives covered for each month of the reported year. See SSAP No. 47—Uninsured Plans.
Medicare Supplement:

Business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statements. Does not include Medicare (Title XVIII) or Medicaid (Title XIX) risk contracts.

Dental-Only:

Policies providing for dental only coverage (dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw) issued as stand-alone dental or as a rider to a medical policy that is not related to the medical policy through, premiums, deductibles or out-of-pocket limits. If dental benefits are part of a comprehensive medical plan, then include data under comprehensive/major medical category. Does not include self-insured business, as well as federal employee’s health benefits plans (FEHBP), or Medicare and Medicaid programs.

Vision-Only:

Policies providing for vision only coverage issued as stand-alone vision or as a rider to a medical policy that is not related to the medical policy through, premiums, deductibles or out-of-pocket limits. Does not include self-insured business, federal employee’s health benefit plans (FEHBP), or Medicare and Medicaid programs.
ANNUAL STATEMENT INSTRUCTIONS – PROPERTY

ACCIDENT AND HEALTH POLICY EXPERIENCE EXHIBIT

This exhibit is required to be filed no later than April 1.

A schedule must be prepared and submitted to the state of domicile for each jurisdiction in which the company has Written Premium (Direct), Earned Premium (Direct, Assumed and Ceded) or Incurred Claims (Direct, Assumed and Ceded). In addition, a schedule must be prepared and submitted that contains the grand total (GT) for the company.

1. The name of the company must be clearly shown at the top of each page or pages.

2. The Exhibit will show information concerning direct business written on policy forms approved for use in the United States with a final total for all policy forms (including non-U.S. policy forms) on the bottom line of the Exhibit.

The Exhibit will show information for each listed product for Individual, Group, and Other business categories. Subtotals by product within the individual category are required for all columns.

3. A Summary Page shows a reconciliation with Schedule H for Individual, Group and Credit policies separately and in total for companies filing the Life, Accident and Health Companies/Fraternal Benefit Societies and Property/Casualty Annual Statement, and a reconciliation of these policies in total only with the specified exhibits of the Health Annual Statement for companies filing that statement.

4. This Exhibit should not include any data pertaining to double indemnity, waiver of premiums and other disability benefits embodied in life contracts.

5. Include membership charges, modal loadings, and policy fees, if any, with premiums earned (Column 1).

DEFINITIONS

Accident Only or AD&D

Policies that provide coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accidents. Types of coverage include student accident, sports accident, travel accident, blanket accident, specific accident or accidental death and dismemberment (AD&D).

Detail Eliminated to Conserve Space

Contract Reserves

Reserves set up when, due to the gross premium structure, the future benefits exceed the future net premium. Contract reserves are in addition to claim and premium reserves.

Credit

Individual or group policies that provide benefits to a debtor for full or partial repayment of debt associated with a specific loan or other credit transaction upon disability or involuntary unemployment of debtor, except in connection with first mortgage loans. In some states, involuntary unemployment credit insurance is not included in health insurance. This category should not include that type of credit insurance in those states.
Dental

Policies providing for dental only coverage (dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw) issued as stand-alone dental or as a rider to a medical policy that is not related to the medical policy through premiums, deductibles or out-of-pocket limits. If dental benefits are part of a comprehensive medical plan, then include data under comprehensive/major medical category. Does not include self-insured business, as well as federal employee’s health benefits plans (FEHBP), or Medicare and Medicaid programs.

Disability Income – Long-Term

Policies that provide a weekly or monthly income benefit for more than five years for individual coverage and more than one year for group coverage for full or partial disability arising from accident and/or sickness. Include policies that provide Overhead Expense Benefits. Does not include credit disability.

TRICARE

Policies issued in association with the Department of Defense’s health care program for active-duty military, active-duty service families, retirees and their families, and other beneficiaries.

CROSS REFERENCES AND OTHER INSTRUCTIONS

The Exhibit

Column 1 – Direct Premiums Written

The grand total reported should equal:

Life/Fraternal  Exhibit 1, Part 1, Lines (6.1+10.1+16.1), Columns (8+9+10),
Health Underwriting and Investment Exhibit, Part 1, Line 9, Column 1,
Property Exhibit of Premiums and Losses, Column 1 sum of Lines 13 through 15.

Column 12 – Direct Premiums Earned

Fractional premium loadings and policy fees must be included in the Earned Premiums.

The Policy Experience Exhibit requires that the Premiums Earned should be on a direct basis, grand total reported should equal:

Life/Fraternal  Exhibit 1, Part 1, Lines (6.1+10.1+16.1), Columns (8+9+10),
Plus Exhibit 1, Part 1, Lines (3.1+13.1), Columns (8+9+10),
Minus Exhibit 6, Line 1, Column 1 CY,
Plus Exhibit 6, Line 1, Column 1 CY,
Minus Exhibit 1, Part 1, Lines (4+14), Columns (8+9+10),
Minus Exhibit 6, Line 5, Column 1 CY,
Plus Exhibit 6, Line 5, Column 1 CY,

Health Underwriting and Investment Exhibit, Part 1, Line 9, Column 1
Less Underwriting and Investment Exhibit Part 2D, Line 1, Column 1 CY
Plus Underwriting and Investment Exhibit Part 2D, Line 1, Column 1 PY
Less Underwriting and Investment Exhibit Part 2D, Line 4, Column 1 CY
Plus Underwriting and Investment Exhibit Part 2D, Line 4, Column 1 PY

Property Exhibit of Premiums and Losses, Column 2 sum of Lines 13 through 15.
<table>
<thead>
<tr>
<th>Column 5</th>
<th>Net Premiums Earned</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>The grand total reported should equal:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Property Schedule H, Part 1, Column 1, Line 2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 26</th>
<th>Direct Incurred Claims Amount</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>This column does not include the “Increase in Policy Reserves.”</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Policy Experience Exhibit requires that the Incurred Claims should be on a direct basis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The grand total reported should equal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Life/Fraternal Exhibit 8, Part 2, Line 6.1, Columns (9+10+11).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Exhibit 6, Line 14, Column 1.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plus Underwriting and Investment Exhibit, Part 2, Line 12.1, Column 1 minus Column 10.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>NOTE:</strong> This excludes payments for any administrative costs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Property Exhibit of Premiums and Losses, Column 6 sum of Lines 13 through 15.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 7</th>
<th>Assumed Incurred Claims Amount</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>The grand total reported should equal:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Underwriting and Investment Exhibit, Part 2, Line 12.2, Column 1 minus Column 10.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Property Underwriting and Investment Exhibit, Part 2, Column 2 sum of Lines 13 through 15.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plus Underwriting and Investment Exhibit, Part 2A, Column 2 sum of Lines 13 through 15 – Current Year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minus Underwriting and Investment Exhibit, Part 2A, Column 2 sum of Lines 13 through 15 – Prior Year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plus Underwriting and Investment Exhibit, Part 2A, Column 6 sum of Lines 13 through 15 – Current Year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minus Underwriting and Investment Exhibit, Part 2A, Column 6 sum of Lines 13 through 15 – Prior Year.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 8</th>
<th>Ceded Incurred Claims Amount</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>The grand total reported should equal:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Underwriting and Investment Exhibit, Part 2, Line 12.3, Column 1 minus Column 10.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Property Underwriting and Investment Exhibit, Part 2, Column 3 sum of Lines 13 through 15.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plus Underwriting and Investment Exhibit, Part 2A, Column 3 sum of Lines 13 through 15 – Current Year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minus Underwriting and Investment Exhibit, Part 2A, Column 3 sum of Lines 13 through 15 – Prior Year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plus Underwriting and Investment Exhibit, Part 2A, Column 7 sum of Lines 13 through 15 – Current Year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minus Underwriting and Investment Exhibit, Part 2A, Column 7 sum of Lines 13 through 15 – Prior Year.</td>
<td></td>
</tr>
</tbody>
</table>
Column 9 — Net Incurred Claims Amount

The grand total reported should equal:

Life\Fraternal: Schedule H, Part 1, Column 1, Line 3
Health: Underwriting and Investment Exhibit, Part 2, Line 12.4, Column 1 minus Column 10.
Property: Schedule H, Part 1, Column 1, Line 3

Column 310 — Change in Contract Reserves

The Policy Experience Exhibit requires that the change in contract reserves should be on a direct basis. This is the direct basis included in the sum of:

Line 2, Grand Total Individual, Group and Other Business of “D” Total Business should equal:

A. The Change in Additional Reserves

Life\Fraternal: Exhibit 6, Lines 2 + 3, Column 1. Current year minus prior year.

B. Plus the Change in the Reserve for Future Contingent Benefits

Life\Fraternal: Exhibit 6, Line 4, Column 1. Current year minus prior year.

C. Less the Change in the Premium Deficiency Reserve

Life\Fraternal and Property: Footnote (a) Schedule H Part 2. Current year minus prior year.
Health: Footnote (a) Underwriting and Investment Exhibit Part 2D. Current year minus prior year.

Column 411 — Loss Ratio

This is the ratio of the Direct Incurred Claims (Column 26) plus the Change in Contract Reserves (Column 310) to Direct Premiums Earned Premiums (Column 12).

Column 512 — Number of Policies or Certificates as of Dec. 31

This is the number of individual policies or group certificates issued to individuals covered under a group policy in force as of Dec. 31 of the reporting year. It is not the number of persons covered under individual policies or group certificates. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity. For Administrative Services Only or Administrative Services Contracts, include the number of persons covered. See SSAP No. 47—Uninsured Plans.
Column 613 – Number of Covered Lives

This is the total number of lives insured, including dependents, under individual policies and group certificates as of Dec. 31 of the reporting year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity. For Administrative Services Only or Administrative Services Contracts, include the number of lives covered. See SSAP No. 47—Uninsured Plans.

Column 714 – Member Months

The sum of total number of lives insured on a pre-specified day of each month of the reported year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity. For Administrative Services Only or Administrative Services Contracts, include the number of lives covered for each month of the reported year. See SSAP No. 47—Uninsured Plans.
SUMMARY

Part 1

Columns 1 and 2 should agree to Schedule H—Part 1, Column 1 minus the sum of Columns 3 and 5, Lines 2 and 3, respectively.

Part 2

Columns 1 and 2 should agree to Schedule H—Part 1, Column 3, Lines 2 and 3, respectively.

Part 3

Columns 1 and 2 should agree to Schedule H—Part 1, Column 5, Lines 2 and 3, respectively.

Part 4

Columns 1 and 2 should agree to Schedule H—Part 1, Column 1, Lines 2 and 3, respectively. Column 3 should agree to Schedule H—Part 1 Line 6 less the change in premium deficiency reserve Footnote (a) Schedule H Part 2 current year minus prior year.
<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<tbody>
<tr>
<td>2020</td>
<td>123</td>
<td>45</td>
<td>67</td>
<td>89</td>
<td>10</td>
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<td>14</td>
<td>16</td>
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<td>2019</td>
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<td>99</td>
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ANNUAL STATEMENT BLANK – LIFE/FRATERNAL, HEALTH AND PROPERTY

© 2021 National Association of Insurance Commissioners
## Accident and Health Policy Experience Exhibit for Year

For the Year Ended December 31, 2021

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**Comprehensive Major Medical**

1. With Contract Reserves
2. Without Contract Reserves
3. Subtotal

**Short-Term Medical**

1. With Contract Reserves
2. Without Contract Reserves
3. Subtotal

**Other Medical (Non-Comprehensive)**

1. With Contract Reserves
2. Without Contract Reserves
3. Subtotal

**Specified/Named Disease**

1. With Contract Reserves
2. Without Contract Reserves
3. Subtotal

**Limited Benefit**

1. With Contract Reserves
2. Without Contract Reserves
3. Subtotal

**Student**

1. With Contract Reserves
2. Without Contract Reserves
3. Subtotal

**Accident Only or AD&D**

1. With Contract Reserves
2. Without Contract Reserves
3. Subtotal

**Disability Income - Short-Term**

1. With Contract Reserves
2. Without Contract Reserves
3. Subtotal
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### Part 1: Individual Policies Summary

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### Part 3: Credit Policies (Individual and Group) Summary

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### Part 4: All Individual, Group, and Credit Policies Summary

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MEMORANDUM

TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
    Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
    Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

CC: Marc Perlman, Investment Counsel, NAIC Securities Valuation Office (SVO)

to Update the Financial Modeling Instructions for RMBS/CMBS Securities and Direct IAO Staff to Produce NAIC
Designation and NAIC Designations Categories for Non-Legacy Securities

DATE: February 03, 2021

1. Summary – On Oct. 11, 2018, the Valuation of Securities (E) Task Force adopted an amendment to delete the
Modified Filing Exempt (MFE) provisions from the P&P Manual and directed a referral to the Statutory Accounting Principles
(E) Working Group recommending the deletion of the MFE provisions from Statement of Statutory Accounting Principles
(SSAP) No. 43R—Loan-Backed and Structured Securities. The effect of these changes resulted in these securities coming
under the filing exempt instructions in the P&P Manual, if they have an Eligible NAIC CRP Credit Rating assigned to them.
This change eliminated using the book adjusted carrying value to determine the NAIC designation for these securities.

The IAO staff reported to the Task Force at the 2019 Summer National Meeting that at some point the NAIC should align the
RMBS/CMBS modeling to provide a single NAIC Designation for modeled RMBS/CMBS. This would have been a change
from the current practice of providing a series of book adjusted carrying value price breakpoints to companies to determine the
NAIC designation. The IAO staff submitted a proposal to the Task Force at the 2019 Fall National Meeting to eliminate the
book adjusted carrying value price breakpoint process but the Task Force decided at the Feb. 4, 2020 meeting to defer such a
change because industry expressed concerns there would be significant adverse risk-based capital (RBC) consequences from
making such a change at that time.

In March 2020, the impact from the pandemic was just beginning to become apparent in the U.S. The pandemic’s effect on
RMBS and CMBS securities became more observable during the 2020 year-end financial modeling process. The 2020 year-
end financial modeling identified several securities that no longer qualified as being zero-loss because more conservative
scenarios, necessary to reflect the economic impact of the pandemic, were applied. Once these securities no longer qualified as
being zero-loss, they became subject to the book adjusted carrying value price breakpoints process. Many of these securities
are owned at a significant premium because of the low interest rate environment and, once the price break points were applied,
securities that would otherwise be considered very high quality were required to be reported as an NAIC 2, 3, or 4 just because
of their book adjusted carrying value and not because of any credit concern.

At the Task Force’s Dec. 18, 2020 meeting, industry, represented by the ACLI, agreed with the IAO staff that the mechanics
of the price break points was causing insurer owned securities with otherwise strong credit to be reported as NAIC 2, NAIC 3
and NAIC 4 under the financial modeling price breakpoints process purely because they are owned at a premium and not
because of their credit risk. It was also discussed that the use of financial modeling price breakpoints process was possibly
disrupting the market for these otherwise high-quality investments. SSG staff at that meeting recommended getting rid of the price breakpoints process.

2. **Recommendation** – The IAO staff recommends that the NAIC move to a single NAIC designation and NAIC designation category for all non-Legacy Securities (those financially modelled RMBS/CMBS securities that closed on or after to Jan. 1, 2013). Moving away from financial modeling price breakpoints process for these non-Legacy Securities will avoid further and future market disruptions and permit a clearer assessment of the credit risk assessment for these securities that will not be impacted by the insurers book adjusted carrying value. Making this change for only non-Legacy Securities preserves their historical treatment. Given the potential impact to SSAP 43R - *Loan-Backed and Structured Securities*, staff recommends a referral to the Statutory Accounting Principles (E) Working Group.

3. **Proposed Amendment** – The following text shows the revisions in Part Four that would appear in the 2020 P&P Manual format.
PART FOUR
THE NAIC STRUCTURED SECURITIES GROUP
DEFINITIONS

1. The following terms used in this Part Four have the meaning ascribed to them below.

- **ABS** stands for asset-backed securities and means structured securities backed by consumer obligations originated in the United States.

- **CMBS** stands for commercial mortgage-backed securities and means structured securities backed by commercial real estate mortgage loans originated in the United States. The definition of CMBS may refer to securitizations backed by commercial mortgages, respectively, originated outside of the United States if and to the extent that the vendor selected by the NAIC to conduct the financial modeling: (a) has the necessary information about the commercial mortgage and commercial mortgage loans originated outside of the United States to fully model the resulting securities; and (b) can adapt the modeling process to account for any structural peculiarities associated with the jurisdiction in which the mortgage was originated.

- **Initial Information** means the documentation required to be filed with an Initial Filing of an RMBS or a CMBS CUSIP, pursuant to the section below and pertaining to Loan Information, Reps and Warranty Information and Structure and Formation Information for the transaction, where:
  - **Loan Information** means a review of the loan files by a third party to assess the sufficiency of legal title and other related issues.
  - **Reps and Warranty Information** means the actual representation and warranties in effect for the securitization given by the mortgage originator(s) to the Trust pertaining to loan origination processes and standards, compliance with applicable law, loan documentation and the process governing put backs of defective mortgages back to the originator(s).
  - **Structure and Formation Information** means the waterfall, as described in the definition of Ongoing Information, information and documentation in the form of legal opinions and documentation governing the formation of the securitization and its entities relative to issues such as bankruptcy remoteness, true sale characterization, the legal standards and procedures governing the securitization and other similar issues.

- **Intrinsic Price** is an output of financial modeling, defined as ‘1 - weighted average of discounted principal loss’ expressed as a percentage, reflecting the credit risk of the security.

- **Legacy Security**, for the purposes of this section shall mean any RMBS and any CMBS that closed prior to January 1, 2013.
- **Official Price Grids** means and refers to those generated by the SSG and provided to an insurance company or insurance companies that own the security for regulatory reporting purposes.

- **Ongoing Information** consists of: (a) tranche level data; such as principal balance, factors, principal and interest due and paid, interest shortfalls, allocated realized losses, appraisal reductions and other similar information for the specific tranche; (b) trust level data, such as aggregate interest and principal and other payments received, balances and payments to non-tranche accounts, aggregate pool performance data and other similar information; (c) loan level performance information; and (d) a computerized model of rules that govern the order and priority of the distribution of cash from the collateral pool (i.e., the “waterfall”) to the holders of the certificates/securities—provided in the format and modeling package used by the NAIC financial modeling vendor.

- **Original Source**, with respect to a specific set of data, means the Trustee, Servicer or similar entity that is contractually obligated under the agreement governing the RMBS or CMBS to generate and maintain the relevant data and information in accordance with standards specified in applicable agreements or an authorized re-distributor of the same.

- **NAIC Designation Intrinsic Price Mapping** is the mapping of the Intrinsic Price to a single NAIC Designation and Designation Category employing the midpoints between each adjoining AVR RBC charges (pre-tax). The midpoints are directly used as the minimum Intrinsic Prices (weighted average loss points) for corresponding NAIC Designations and Designation Categories.

- **Price Grids** means and refers to CUSIP-specific price matrices containing six price breakpoints; i.e., each price corresponding to a specific NAIC Designation category. Each breakpoint on a Price Grid is the price point that tips the NAIC Designation for the RMBS CUSIP into the next NAIC Designation (credit quality/credit risk) category. The plural is used because two Price Grids are generated for any CUSIP. This reflects the difference in RBC for those insurance companies that maintain an asset valuation reserve and for those insurance companies that do not.

- **Re-REMIC** is a securitization backed by: (a) otherwise eligible RMBS from one or two transactions; or (b) otherwise eligible CMBS from one or two transactions at closing. Re-REMICs cannot acquire any Underlying Securities after closing.
RMBS stands for residential mortgage-backed securities and means structured securities backed by non-agency residential mortgages originated in the United States, where the collateral consists of loans pertaining to non-multi-family homes. That includes prime, subprime and Alt-A mortgages, as well as home-equity loans, home-equity lines of credit and Re-REMICs of the above. Excluded from this definition is agency RMBS, where the mortgages are guaranteed by federal and federally sponsored agencies such as the Government National Mortgage Association (GNMA), Federal National Mortgage Association (FNMA) or Federal Home Loan Mortgage Corporation (FHLMC) and loans against manufactured or mobile homes or collateralized debt obligations backed by RMBS. The exclusion covers bonds issued and guaranteed by, or only guaranteed by, the respective agency. Also not included are loans guaranteed by the U.S. Department of Veteran Affairs or the U.S. Department of Agriculture’s Rural Development Housing and Community Facilities Programs. The definition of RMBS may refer to securitizations backed by residential mortgages, respectively, originated outside of the United States if and to the extent that the vendor selected by the NAIC to conduct the financial modeling: (a) has the necessary information about the residential mortgage and residential mortgage loans originated outside of the United States to fully model the resulting securities; and (b) can adapt the modeling process to account for any structural peculiarities associated with the jurisdiction in which the mortgage was originated.

Underlying Security means the RMBS or CMBS backing a Re-REMIC. A Re-REMIC cannot be an Underlying Security.

NOTE: The definitions of RMBS and CMBS reflect limitations associated with the financial modeling process, NAIC credit rating provider (CRP) internal naming conventions and SSG processes, as more fully discussed below and may, therefore, be subject to a narrower or a broader reading in any reporting period. Please call the SSG with any concerns or questions about the scope of the definitions for a given reporting period. Also note:

- It is possible that the scope of the RMBS and CMBS definitions may be broadened because the financial modeling vendors indicate other collateral or waterfall structures can be modeled.
- NAIC CRPs may adopt different internal conventions with respect to what market or asset segments are within their rated populations of RMBS, CMBS or ABS. This could affect the application of the adopted NAIC methodology or require the NAIC to select which naming process it wishes to adopt.
- It is possible that the SSG will acquire analytical assessment capabilities that permit the assessment of existing, additional or different structured securities that cannot now be modeled or that are not currently rated.
ADMINISTRATIVE AND OPERATIONAL MATTERS

Certain Administrative Symbols

2. The following administrative symbols are used in the Valuation of Securities (VOS) Products to identify RMBS and CMBS that the NAIC vendor has confirmed will be subject to the financial modeling methodology described in this Part.

- **FMR** – Indicates that the specific CUSIP identifies a Legacy Security RMBS that is subject to the financial modeling methodology and the application of Price Grids to determine a NAIC Designation and Designation Category.

- **FMC** – Indicates that the specific CUSIP identifies a Legacy Security CMBS that is subject to the financial modeling methodology and the application of Price Grids to determine a NAIC Designation and Designation Category.

- **FSR** – Indicates that the specific CUSIP identifies a non-Legacy Security RMBS that is subject to the financial modeling methodology and assignment of a NAIC Designation and Designation Category by the SSG.

- **FSC** – Indicates that the specific CUSIP identifies a non-Legacy Security CMBS that is subject to the financial modeling methodology and assignment of a NAIC Designation and Designation Category by the SSG.

**NOTE:** The administrative symbols **FMR**, **FMC**, **FSR** and **FSC** are related to symbols that insurers are required to use in the financial statement reporting process. Under applicable financial statement reporting rules, an insurer uses the symbol **FM** as a suffix to identify Legacy Security modeled RMBS and CMBS CUSIPs and **FS** as a suffix to identify non-Legacy Security modeled RMBS and CMBS CUSIPs. The symbol **FM** or **FS** is inserted by the insurer in the financial statement as a suffix following the NAIC Designation Category; e.g., **2.B FM**, **3.C FS**.

The use of these administrative symbols in the VOS Product means the insurer should not use the filing exempt process for the security so identified.
Quarterly Reporting of RMBS and CMBS

3. To determine the NAIC Designation to be used for quarterly financial statement reporting for an RMBS or CMBS purchased subsequent to the annual surveillance described in this Part, the insurer uses the prior year-end modeling data for that CUSIP (which can be obtained from the NAIC) and follows the instructions in contained under the heading “Use of Net Present Value and Carrying Value for Financially Modelled Legacy Security RMBS and CMBS” below or follows the instructions in “Publication of Final Results: Use of Intrinsic Price for Financially Modeled non-Legacy Security RMBS and CMBS” below, subject to, and in accordance with, SSAP No. 43R—Loan-Backed and Structured Securities.
**FILING EXEMPTIONS**

**Limited Filing Exemption for RMBS and CMBS**

4. **RMBS and CMBS that Can be Financially Modeled** – RMBS and CMBS that can be financially modeled are exempt from filing with the SVO. NAIC Designations for RMBS and CMBS that can be financially modeled are determined by application of the methodology discussed in this Part, not by the use of credit ratings of CRPs.

5. **RMBS and CMBS securities that Cannot be Financially Modeled**
   - **But Are Rated by a CRP** – RMBS and CMBS that cannot be financially modeled but that are rated by a CRP are exempt from filing with the SSG. The NAIC Designations for these RMBS and CMBS are determined by application of the filing exemption procedures discussed in this Manual.
   - **But Are Not Rated by a CRP** – RMBS and CMBS that cannot be financially modeled and that are not rated by a CRP are not filing exempt and must be filed with the SSG or follow the procedures, as discussed below in this Part.

**Filing Exemption for ABS**

6. ABS rated by a CRP are exempt from filing with the SSG.

**Review of Decisions of the SSG**

7. Analytical decisions made through the application of financial modeling are not subject to the appeal process. In the absence of an appeal, the SSG shall provide whatever clarification as to the results of financial modeling is possible to any insurer who requests it and owns the security, provided that it is not unduly burdensome for the SSG to do so. Any decision made by the SSG that results in the assignment of an NAIC Designation and does not involve financial modeling methodology, whether developed by the SSG on its own or in collaboration with the SVO, is subject to the appeal process.
8. The policy statement set forth in this section shall be applicable generally to any transaction filed with the SSG for an analytical assessment, including, but not limited to, a Price Grid or for assignment of an NAIC Designation. Any filing with the SSG is deemed to be incomplete unless the insurer has provided the information, documentation, and data in quantity and quality sufficient to permit the SSG to conduct an analysis of the creditworthiness of the issuer and the terms of the security to determine the requested analytical value. It is the obligation of the reporting insurance company to provide the SSG with all necessary information. It is the responsibility of the SSG to determine whether the information provided is sufficient and reliable for its purposes and to communicate informational deficiencies to the reporting insurance company.

Documentation Standards

9. In order for an insurer-owned RMBS or CMBS to be eligible for the year-end modeling process, conducted pursuant to this section below, the analysis must be based on information, documentation and data of the utmost integrity. A Legacy Security must meet the Ongoing Information requirements. An RMBS, CMBS or Re-REMIC that is not a Legacy Security must meet the Initial Information and Ongoing Information requirements. For the purposes of determining a Re-REMIC’s status as a Legacy Security, the closing date of the Re-REMIC (not the Underlying Security) shall be used. The SSG may, in its sole discretion, determine that the Initial Information and/or Ongoing Information is not sufficient and/or not reliable to permit the RMBS or CMBS CUSIP to be eligible for financial modeling. If the SSG determines that the Initial Information and/or Ongoing Information is not sufficient and/or not reliable to permit the RMBS or CMBS CUSIP to be eligible for financial modeling, it will communicate this decision to the insurer and invite a dialogue to ascertain whether alternative information is available that would be deemed sufficient and/or reliable by the SSG.

Initial Information Requirements

10. An RMBS or CMBS meets the Initial Information Requirements if the security meets one of the following three conditions:

- **RTAS** – The RMBS or CMBS was assigned a preliminary price grid or designation as described in this Part;
- **Initial Sufficiency Filing** – The RMBS or CMBS was reviewed by SSG through an Initial Sufficiency Filing; or
- **Safe Harbor** – The RMBS or CMBS meets the Safe Harbor requirements.
Initial Sufficiency Information Filing

11. An insurance company may file Initial Sufficiency Information with the SSG for the purpose of obtaining a determination that an RMBS or CMBS CUSIP is eligible for financial modeling under the annual surveillance process discussed below. Initial Sufficiency Information is only filed once for any given RMBS or CMBS. Reporting insurance companies are solely responsible for providing the SSG with Initial Information. A determination by the SSG that a given RMBS or CMBS CUSIP is eligible for financial modeling after an Initial Sufficiency Filing assessment is subject to the further and continuing obligation that the SSG obtain or the insurer provide the SSG with updated Ongoing Information close to the date of the annual surveillance.

12. Required Documents for Initial Sufficiency Filing – An insurer that owns an RMBS or a CMBS for which Initial Information is not publicly available shall provide the SSG with the following documentation.

13. RMBS – Unless otherwise specified by the SSG in a Modeling Alert, as further described below, an Initial Filing for an RMBS consists of submission of Initial Information and Ongoing Information in the form of the following documentation:

- Pooling and Servicing Agreement or similar
- Prospectus, Offering Memorandum or similar; Accountant’s comfort letter
- If applicable, ISDA Schedules and Confirmations or similar
- Legal opinions given in connection with the transaction
- Any other documents referenced by the above
- Third-Party Due diligence scope document and raw results. If less than 100% due diligence, detailed description of the loan selection process
- If applicable, loan purchase agreements or similar. Loan Tape

14. CMBS – Unless otherwise specified by the SSG in a Modeling Alert, as further described below, an Initial Filing for a CMBS consists of submission of Initial Information and Ongoing Information in the form of the following documentation:

- Pooling and Servicing Agreement or similar
- Prospectus, Offering Memorandum or similar; Accountant’s comfort letter
- If applicable, ISDA Schedules and Confirmations or similar
- Legal opinion given in connection with the transaction
- Any other documents referenced in the above
- Asset Summaries
- Loan Tape
- Loan documents, including reliable information about the terms of the transaction; including, but not limited to, financial covenants, events of default, legal remedies and other information about financial, contractual or legal aspects of the transaction in form and substance consistent with industry best practices for CMBS issuance.
- In certain cases, additional documents below will enable the SSG to verify and validate initial underwriting information of the property securing the CMBS. These documents may be required in form and substance consistent with best practices for typical CMBS issuance.
- Historical operating statements and borrower’s budget
- Underwriter’s analysis of stabilized cash flow with footnotes of assumptions used
- Property type specific, rent roll information
- Appraisals and other data from recognized industry market sources
- Independent engineering report (Property Condition Assessment)
- Environmental Site Assessment (ESA) – Phase I/Phase II
- Documentation related to seismic, flood and windstorm risks
- Franchise agreements and ground leases, if applicable
- Management agreements

**SSG Modeling Alerts**

15. The SSG shall at all times have discretion to determine that differences in the structure, governing law, waterfall structure or any other aspect of a securitization or a class of securitization requires that insurance companies provide Initial Information and/or Ongoing Information additional to or different from that identified in this Part. The SSG shall communicate such additional or different documentation requirements to insurers by publishing a Modeling Alert on the NAIC website and scheduling a meeting of the VOS/TF to ensure public dissemination of the decision.

**Safe Harbor**

16. Safe Harbor options serve as proxies for the Initial Sufficiency filing. The options reflect publicly available information that a third party has analyzed the Initial Information. Because the structured securities market is quite dynamic, the list of Safe Harbor options may change frequently, with
notice and opportunity for comment, as described in this section. An RMBS or CMBS meets the Initial Information requirement if:

- At least two Section 17(g)-7 reports issued by different CRPs are publicly available; or
- A security that is publicly registered under the federal Securities Act of 1933.

Ongoing Information Requirements

17. An RMBS or CMBS meets the Ongoing Information Requirements if Ongoing Information is available to the SSG and the relevant third-party vendor from an Original Source. The SSG, in its sole discretion and in consultation with the relevant third-party vendor, may determine that the Ongoing Information is not sufficient or reliable to permit a given RMBS or CMBS CUSIP to be financially modeled. However, in making such a determination, the SSG shall take into account reasonable market practices and standards.

Special Rules for Certain Re-REMICs

18. Re-REMICs are generally simple restructurings of RMBS or CMBS. An Initial Sufficiency Filing for a Re-REMIC (a) which is not a Legacy Security itself but (b) where each Underlying Security is a Legacy Security shall not require submission of information regarding the Underlying Securities. In most cases, a prospectus for the Re-REMIC will be sufficient. If the SSG determines that additional information about the Re-REMIC structure or formation is required, it will communicate this decision to the insurer and invite a dialogue to ascertain whether additional information is available that would be deemed sufficient by the SSG.
ANALYTICAL ASSIGNMENTS

ANNUAL SURVEILLANCE OF RMBS AND CMBS – MODELED AND NON-MODELED SECURITIES

Scope

19. This section explains the financial modeling methodology applicable to all RMBS and CMBS (defined above) securitizations, and the book/adjusted carrying value methodology applicable to a modeled Legacy Security, the NAIC Designation Intrinsic Price Mapping applicable to a modeled non-Legacy Security, and non-modeled securities subject to SSAP No. 43R—Loan-Backed and Structured Securities. Please refer to SSAP No. 43R for a description of securities subject to its provisions. The VOS/TF does not formulate policy or administrative procedures for statutory accounting guidance. Reporting insurance companies are responsible for determining whether a security is subject to SSAP No. 43R and applying the appropriate guidance.

Important Limitation on the Definitions of RMBS and CMBS

20. The definitions of RMBS and CMBS above are intended solely to permit the SSG to communicate with financial modeling vendors, insurance company investors who own RMBS and CMBS subject to financial modeling and/or the book/adjusted carrying value methodology and their investment advisors to facilitate the performance by the SSG of the financial modeling methodology described below. The definitions contained in this section are not intended for use and should not be used as accounting or statutory statement reporting instructions or guidance.

NOTE: Please refer to SSAP No. 43R—Loan-Backed and Structured Securities for applicable accounting guidance and reporting instructions.

ANALYTICAL PROCEDURES APPLICABLE TO RMBS AND CMBS SECURITIZATIONS SUBJECT TO FINANCIAL MODELING METHODOLOGY

Filing Exemption Status of RMBS and CMBS

21. RMBS and CMBS are not eligible for the filing exemption because credit ratings of CRPs are no longer used to set risk-based capital (RBC) for RMBS or CMBS. However, RMBS and CMBS are not submitted to the SSG.

Use of Financial Modeling for Year-End Reporting for RMBS and CMBS

22. Beginning with year-end 2009 for RMBS and 2010 for CMBS, probability weighted net present values will be produced under NAIC staff supervision by an NAIC-selected vendor using its financial model with defined analytical inputs selected by the SSG. The vendor will provide the SSG with an Intrinsic Price and/or a range of net present values for each RMBS or CMBS.
corresponding to each NAIC Designation category. The NAIC Designation for a specific Legacy Security RMBS or CMBS is determined by the insurance company, based on book/adjusted carrying value ranges, and the NAIC Designation for a specific non-Legacy Security RMBS or CMBS is determined by the NAIC Designation Intrinsic Price Mapping by SSG.

NOTE: Please refer to SSAP No. 43R—Loan-Backed and Structured Securities for guidance on all accounting and related reporting issues.

Analytical Procedures for RMBS and CMBS

23. The SSG shall develop and implement all necessary processes to coordinate the engagement by the NAIC of a vendor who will perform loan-level analysis of insurer-owned RMBS and CMBS using the vendor’s proprietary models.

RMBS AND CMBS SUBJECT TO FINANCIAL MODELING

Setting Microeconomic Assumptions and Stress Scenarios

24. Not later than September of each year, the SSG shall begin working with the vendor to identify the assumptions, stress scenarios and probabilities (hereafter model criteria) the SSG intends to use at year-end to run the vendor’s financial model.

The Financial Modeling Process

25. Information about the financial modeling process can be found at www.naic.org/structured_securities/index_structured_securities.htm.

Use of Net Present Value and Carrying Value for Financially Modeled Legacy Security RMBS and CMBS

26. For each modeled Legacy Security RMBS and CMBS, the financial model determines the net present value at which the expected loss equals the midpoint between the RBC charges for each NAIC Designation; i.e., each price point, if exceeded, changes the NAIC Designation. Net present value is the net present value of principal losses, discounted using the security’s coupon rate (adjusted in case of original issue discount securities to book yield at original issue and in case of floating rate securities, discounted using LIBOR curve + Origination spread). Because of the difference in RBC charge, the deliverable is five values for each RMBS and CMBS security for companies required to maintain an asset valuation reserve (AVR) and five values for companies not required to maintain an AVR. This is illustrated in the chart below.
27. The NAIC Designation and NAIC Designation Category for a given modeled Legacy Security RMBS or CMBS CUSIP owned by a given insurance company depends on the insurer's book/adjusted carrying value of each RMBS or CMBS, whether that carrying value, in accordance with SSAP No. 43R—Loan-Backed and Structured Securities, paragraphs 25 through 26a, is the amortized cost or fair value, and where the book/adjusted carrying value matches the price ranges provided in the model output for each NAIC Designation and the mapped NAIC Designation Category, reflected in the table below, to be used for reporting an NAIC Designation Category until new Risk Based Capital factors are adopted for each NAIC Designation Category and new prices ranges developed; except that an RMBS or CMBS tranche that has no expected loss under any of the selected modeling scenarios and that would be equivalent to an NAIC 1 Designation if the filing exempt process were used, would be assigned an NAIC 1 Designation and NAIC 1.D Designation Category regardless of the insurer's book/adjusted carrying value.

**NOTE:** Please refer to the detailed instructions provided in SSAP No. 43R.
Use of Intrinsic Price for Financially Modeled non-Legacy Security RMBS and CMBS

28. The NAIC Designation and NAIC Designation Category for a given modeled non-Legacy Security RMBS or CMBS CUSIP owned by a given insurance is assigned by SSG and does not depend on the insurer’s book/adjusted carrying value of each RMBS or CMBS. The NAIC Designation and Designation Category assigned will be determined by applying the Intrinsic Price to the NAIC Designation Intrinsic Price Mapping, as defined in this Part.

29. Securities subject to SSAP No. 43R—Loan-Backed and Structured Securities that cannot be modeled by the SSG and are not rated by an NAIC CRP or designated by the SVO are either: (a) assigned the NAIC administrative symbol ND (not designated), requiring subsequent filing with the SVO; or (b) assigned the NAIC Designation for Special Reporting Instruction [i.e., an NAIC 5GI, NAIC Designation Category NAIC 5.B GI or NAIC 6* (six-star)].
MORTGAGE REFERENCED SECURITIES

Definition

30. A Mortgage Referenced Security has the following characteristics: A Mortgage Referenced Security’s coupon and/or principal payments are linked, in whole or in part, to prices of, or payment streams from, real estate, index or indices related to real estate, or assets deriving their value from instruments related to real estate, including, but not limited to, mortgage loans.

Not Filing Exempt

31. A Mortgage Referenced Security is not eligible for filing exemption but is subject to the filing requirement.

NAIC Risk Assessment

32. In determining the NAIC Designation of a Mortgage Referenced Security, the SSG may use the financial modeling methodology discussed in this Part, adjusted (if and as necessary) to the specific reporting and accounting requirements applicable to Mortgage Referenced Securities.

Quarterly Reporting for Mortgage Reference Securities

33. To determine the NAIC Designation to be used for quarterly financial statement reporting for a Mortgage Reference Security purchased subsequent to the annual surveillance described in this Part, the insurer uses the prior year-end modeling data for that CUSIP (which can be obtained from the NAIC) until the annual surveillance data is published for the current year. For a Mortgage Reference Security that is not in the prior year-end modeling data for that CUSIP, the insurer may follow the instructions in Part Two of this manual for the assignment of the SVO Administrative Symbol “Z” provided the insurer owned security meets the criteria for a security that is in transition in reporting or filing status.

NOTE: Please refer to SSAP No. 26R and SSAP No. 43R for the definition of and guidance on Structured Notes and Mortgage Referenced Securities. Please also refer to Part Three of this Manual for guidance about the filing exempt status of Structured Notes.
GROUND LEASE FINANCING TRANSACTIONS

Definition

34. Ground Lease Financing (GLF) transactions are defined and explained in “Ground Lease Financing Transactions” in Part Three of this Manual.

SSG Role and Process

1. On occasion, the SVO may refer a GLF transaction to the SVO for financial modeling of the GLF space leases or business operation, as applicable, in accordance with the process set forth in “Ground Lease Financing Transactions” in Part Three of this Manual. Following an SVO referral the SSG and SVO will maintain open communication related to requests for additional data, analytical questions and analytical conclusions. Any GLF transaction NAIC Designation will be assigned by the SVO.
THE RTAS – EMERGING INVESTMENT VEHICLE

Purpose

2. Price grids and/or Designations and Designation Categories are generated for the exclusive use of insurance companies and the NAIC regulatory community. Insurance companies use official Price Grids and/or Designations and Designation Categories by following the instructions in SSAP No. 43R—Loan-Backed and Structured Securities to derive a final NAIC Designation for the RMBS or CMBS, which they use to derive the RBC applicable for the RMBS or CMBS.

NOTE: Please refer to SSAP No. 43R for a full explanation of the applicable procedure.

Extension of Authority

3. The Regulatory Treatment Assessment Service – Emerging Investment Vehicle procedure is extended to the SSG, and the SSG is authorized to determine probable regulatory treatment for RMBS and CMBS pursuant to this Part or for other securities, where, in the opinion of the SSG, financial modeling methodology would yield the necessary analytical insight to determine probable regulatory treatment or otherwise enable the SSG to make recommendations to the VOS/TF as to regulatory treatment for a security.

Interpretation

4. To facilitate this purpose, wherever in the Regulatory Treatment Assessment Service – Emerging Investment Vehicle procedure reference is made to the SVO, it shall be read to also refer to and apply to the SSG, adjusting for differences in the operational or methodological context. The Regulatory Treatment Assessment Service – Emerging Investment Vehicle procedure shall also be read as authority for collaboration between SVO and SSG staff functions so as to encompass RTAS assignments that require the use of SVO financial, corporate, municipal, legal, and structural analysis and related methodologies, as well as of financial modeling methodologies.

Translation of Preliminary into Official Price Grids and/or NAIC Designations and Designation Categories

5. Price Grids and/or Designations and Designation Categories (“PGD”) generated by the SSG pursuant to an RTAS are preliminary within the meaning of that term as used in the Regulatory Treatment Assessment Service – Emerging Investment Vehicle procedure and accordingly cannot be used for official NAIC regulatory purposes. Preliminary NAIC Designations are translated into official NAIC Designations by the SVO when an insurance company purchases and files the security and the SVO conducts an official assessment. However, this Manual does not require the filing of RMBS and CMBS subject to financial modeling methodology with the SSG. It is, therefore, necessary to specify a procedure for the translation of preliminary Price Grids and/or
Designations and Designation Categories (‘Preliminary PGD’) into official Price Grid PGD that can be used for NAIC regulatory purposes. Preliminary Price Grid PGDs generated by the SSG become an official Price Grid PGD within the meaning of this section when an insurance company has purchased the security for which the Price Grid PGD was generated and reported that security for quarterly reporting purposes using the SSG generated Price Grid PGD. A Price Grid PGD for a security reported by an insurance company for quarterly reporting is effective until the SSG conducts the next annual surveillance pursuant to this Part at which time the Price Grid PGDs generated by the SSG at year-end shall be the official Price Grid PGDs for that security.
## Blanks (E) Working Group

### Editorial Revisions to the Blanks and Instructions

*(presented at the March 16, 2021, Meeting)*

Statement Type:

- **H** = Health
- **L/F** = Life/Fraternal Combined
- **P/C** = Property/Casualty
- **SA** = Separate Accounts
- **T** = Title

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<td>2021</td>
<td>Life, Health and Annuity Guaranty Association Assessable Premium Exhibit – Parts 1</td>
<td><strong>CHANGE TO BLANK</strong>&lt;br&gt;Put XXX in Columns 1 and 3 for line 4.99 and modify the section header between Line 5 and Line 6 as shown below.&lt;br&gt;DEVELOPMENT OF AMOUNTS INCLUDED IN LINES 1 THROUGH 5 THAT SHOULD BE DEDUCTED IN DETERMINING THE BASE PRIOR TO ADDITIONAL ADJUSTMENTS IN PART 2&lt;br&gt;Do not include any amounts more than once in Lines 6 through 9</td>
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<td>2021</td>
<td>Life, Health and Annuity Guaranty Association Assessable Premium Exhibit – Part 2</td>
<td><strong>CHANGE TO BLANK</strong>&lt;br&gt;Made Premium plural in column headers 1 and 3 to agree with Part 1.&lt;br&gt;Life Insurance Premiums&lt;br&gt;Accident &amp; Health Premiums</td>
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<td>2021</td>
<td>Life, Health and Annuity Guaranty Association Assessable Premium Exhibit – Parts 1</td>
<td><strong>CHANGE TO INSTRUCTION</strong>&lt;br&gt;Modify the instruction from Part 1 as shown below.&lt;br&gt;Development of Amounts Included in Lines 1 Through 5 That Should Be Deducted in Determining the Gross Premium Base Prior to Additional Adjustments in Part 2</td>
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<td>Notes to Financial Statements</td>
<td><strong>CHANGE TO INSTRUCTION</strong>&lt;br&gt;Modify the instruction for Note 10O as shown below. Modify the illustration for Not 10O to replace the column header “Reported Value” with “Amount of Guarantee Recognized Under SSAP No. 5R”.&lt;br&gt;- The SCA or SSAP No. 48 entity’s reported value of the amount of the recognized guarantee under SSAP No. 5R.</td>
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<td>2021</td>
<td>Schedule BA, Part 1</td>
<td>CHANGE TO INSTRUCTION</td>
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<td>Make the following edits to the Column 7 instructions to clarify lines where NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol are made.</td>
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<td>Column 7 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol</td>
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<td>This column must be completed for those investments included on Lines 0799999, 0899999, 1599999, 1699999 and 164599999. For all other lines the column may be completed if the investment has an NAIC Designation received from the SVO or from an NAIC CRP.</td>
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<td>For Schedule BA, the investments noted above with the underlying characteristics of a bond or a preferred stock instrument, insert the appropriate combination of the NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol. The list of valid SVO Administrative Symbols is shown below.</td>
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<td>NAIC Designation Modifier:</td>
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<td>The NAIC Designation Modifier should only be used for securities reported on the lines below if eligible to receive one, as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&amp;P Manual), otherwise, the field should be left blank.</td>
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<td>Underlying Characteristics of Bonds:</td>
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<td>Lines 0799999 through 0899999</td>
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<td>Underlying Characteristics of Preferred Stocks:</td>
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<td>Lines 1599999 through 1699999</td>
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<td>As defined in the P&amp;P Manual, there is not an NAIC Designation Modifier for investments reporting an NAIC Designation 6, therefore, the NAIC Designation Modifier field should be left blank.</td>
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<td>Refer to the P&amp;P Manual for the application of these modifiers.</td>
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<td>The NAIC designation NAIC Designation Modifier and SVO Administrative Symbol field should be left blank for those Schedule BA investments that have not been assigned an NAIC designation by the Securities Valuation Office (SVO) pursuant to the policies in the Purposes and Procedures Manual of the NAIC Investment Analysis Office.</td>
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<td>The NAIC Designation Category is the combination of NAIC Designation and NAIC Designation Modifier. Valid combinations of NAIC Designation and NAIC Designation Modifier for NAIC Designation Category are shown below:</td>
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| 2021      | Schedule BA, Part 2 | **CHANGE TO INSTRUCTION**<br>Make the following edits to the Column 6 instructions to clarify lines where NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol are made.<br><br>Column 6 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol<br>This column must be completed for those investments included on Lines 0799999, 0899999, 1599999, 1699999 and 1645999. For all other lines the column may be completed if the investment has an NAIC Designation received from the SVO or from an NAIC CRP.<br><br>For Schedule BA, the investments noted above with the underlying characteristics of a bond or a preferred stock instrument, insert the appropriate combination of the NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol. The list of valid SVO Administrative Symbols is shown below.<br><br>*****Detail Eliminated to Conserve Space*****<br><br>**NAIC Designation Modifier:**<br>The NAIC Designation Modifier should only be used for securities reported on the lines below if eligible to receive one, as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), otherwise, the field should be left blank.<br><br> Underlying Characteristics of Bonds: Lines 0799999 through 0899999<br> Underlying Characteristics of Preferred Stocks: Lines 1599999 through 1699999<br><br>As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments reporting an NAIC Designation 6, therefore, the NAIC Designation Modifier field should be left blank.<br><br>Refer to the P&P Manual for the application of these modifiers.<br><br>**SVO Administrative Symbol:**<br>*****Detail Eliminated to Conserve Space*****<br><br>The NAIC designation NAIC Designation Modifier and SVO Administrative Symbol field should be left blank for those Schedule BA investments that have not been assigned an NAIC designation by the Securities Valuation Office (SVO) pursuant to the policies in the Purposes and Procedures Manual of the NAIC Investment Analysis Office.<br><br>The NAIC Designation Category is the combination of NAIC Designation and NAIC Designation Modifier. Valid combinations of NAIC Designation and NAIC Designation Modifier for NAIC Designation Category are shown below:
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<td>Analysis of Operations by Lines of Business – Individual Life Insurance</td>
<td><strong>CHANGE TO INSTRUCTION</strong>&lt;br&gt;The instruction for Column 5 is in conflict with adopted guidance for the Valuation Manual for PBR and the VM-20 Supplement. The change below removes that conflict.&lt;br&gt;&lt;br&gt;Column 5 – Indexed Life&lt;br&gt;  Exclude: Indexed universal life with secondary guarantees.&lt;br&gt;  Include: Indexed universal life with secondary guarantees.&lt;br&gt;&lt;br&gt;Column 7 – Universal Life with Secondary Guarantees&lt;br&gt;  Include: Indexed universal life with secondary guarantees.</td>
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<td>Schedule D, Part 1</td>
<td><strong>CHANGE TO INSTRUCTION</strong>&lt;br&gt;Make the following addition to the instructions to Columns 27 and 28.&lt;br&gt;&lt;br&gt;Column 27 – Call Date&lt;br&gt;  Report the call date used to calculate the Effective Date of Maturity. If call date does not affect the Effective Date of Maturity field but exists, report the next call date. If there is no call date, leave blank.&lt;br&gt;&lt;br&gt;Column 28 – Call Price&lt;br&gt;  Report the call price used to calculate the Effective Date of Maturity. If call price does not affect the Effective Date of Maturity field but exists, report the next call price. If there is no call price, leave blank.</td>
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<td>Schedule Y, Part 1A</td>
<td><strong>CHANGE TO BLANK</strong>&lt;br&gt;Change Column 15 header description as shown below.&lt;br&gt;&lt;br&gt;Is an SCA Filing Required? (Yes/No)</td>
<td>H, L/F, P/C, T</td>
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<td>Change Column 15 instructions as shown below.</td>
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<td>Column 15 – Is an SCA Filing Required? (Yes/No)</td>
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<td>Answer “Yes (Y)” or “No (N)” if an SCA (Subsidiary, Controlled and Affiliated) SUB 1 (initial) or SUB 2 (annual) filing with the NAIC is required per SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities for the entity in Column 8.</td>
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<td>Schedule Y, Part 1A</td>
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<td>Answer “Yes (Y)” or “No (N)” if an SCA (Subsidiary, Controlled and Affiliated) SUB 1 (initial) or SUB 2 (annual) filing with the NAIC is required per SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities for the entity in Column 8.</td>
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<td>Analysis of Operations by Lines of Business – Summary</td>
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<td>Remove the crosscheck below. The count for group policies on the Life Insurance (state page) is policies not certificates as should be reported on the Analysis of Operations by Lines of Business – Summary page.</td>
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<td>Line 34 – Policies/Certificates in Force End of Year</td>
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<td>The number provided should be count of direct written policies/certificates in force at the end of the year.</td>
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<td>The sum of Columns 2 and 3 should equal Line 23, Column 9 of Life Insurance (state page).</td>
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The Capital Adequacy (E) Task Force met March 23, 2021. The following Task Force members participated: Judith L. French, Chair, represented by Tom Botsko (OH); Doug Slape, Vice Chair, represented by Mike Boerner and Rachel Hemphill (TX); Lori K. Wing-Heier represented by Wally Thomas (AK); Jim L. Ridling represented by Richard Ford (AL); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by Philip Barlow (DC); David Altmaier represented by Carolyn Morgan (FL); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Seervinghaus represented by Vincent Tsang (IL); Vicki Schmidt represented by Tish Becker (KS); Grace Arnold represented by John Robinson (MN): Chlora Lindley-Myers represented by John Rehagen (MO); Mike Causey represented by Jackie Obusek (NC); Bruce R. Ramge represented Lindsay Crawford (NE); Marlene Caride represented by Diana Carter (OK); Raymond G. Farmer represented Michael Shull (SC); Mike Kreidler represented by Steve Drutz (WA); and Mark Afable represented by Amy Malm (WI).

1. **Adopted its Feb. 1, 2021, and 2020 Fall National Meeting Minutes**

The Task Force conducted an e-vote that concluded Feb. 1 to adopt the 2020 catastrophe event list.

Mr. Yanacheak made a motion, seconded by Mr. Chou, to adopt the Task Force’s Feb. 1, 2021 (Attachment One) and Nov. 19, 2020 (see NAIC Proceedings – Fall 2020, Capital Adequacy (E) Task Force) minutes. The motion passed unanimously.

2. **Adopt its Working Group Reports and Minutes**

   a. **Health Risk-Based Capital (E) Working Group**

   Mr. Drutz said the Health Risk-Based Capital (E) Working Group’s met March 17 and took the following action: 1) adopted its Feb. 10, 2021; Jan. 22, 2021; and Dec. 18, 2020, minutes; 2) adopted its 2021 working agenda; 3) referred proposal 2021-02-CA (Managed Care Credit – Incentives) to the Capital Adequacy (E) Task Force for exposure; 4) continued discussion of the impact analysis on the inclusion of investment income in underwriting risk; 5) exposed proposal 2021-04-CA for a 30-day public comment period; and 6) received an update on the bond factor analysis.

   b. **Life Risk-Based Capital (E) Working Group**

   Mr. Barlow said that the Life Risk-Based Capital (E) Working Group met March 12 and took the following action: 1) adopted its interim minutes; 2) discussed the Moody’s Analytics report on bonds; and 3) discussed the real estate proposal submitted by the American Council of Life Insurers (ACLI). He said the Working Group’s main focus has been on the real estate and bond factors for year-end 2021.

   c. **Catastrophe Risk (E) Subgroup**

   Mr. Chou noted that the Catastrophe Risk (E) Subgroup met March 8 and took the following action: 1) adopted its Jan. 27 minutes; 2) adopted proposal 2020-08-CR (Clarification to PR027 Interrogatories); 3) adopted proposal 2020-11-CR (Remove Operational Risk Factor from Contingent Credit Risk); 4) discussed the development progress of wildfire modeling and a risk-based capital (RBC) charge; 5) discussed its 2021 working agenda; 6) discussed the internal catastrophe model evaluation process; and 7) established an ad hoc group to conduct a more in-depth review on different wildfire models.

   d. **Property and Casualty Risk-Based Capital (E) Working Group**

   Mr. Botsko said that the Property and Casualty Risk-Based Capital (E) Working Group met March 15 and took the following action: 1) exposed a credit risk instruction modification; and 2) heard an update from its Runoff Ad Hoc Group.

Ms. Hemphill made a motion, seconded by Mr. Drutz, to adopt the reports of the Health Risk-Based Capital (E) Working Group (Attachment Two), the Life Risk-Based Capital (E) Working Group (Attachment Three), and the Property and Casualty Risk-Based Capital (E) Working Group (Attachment Four). The motion passed unanimously.
3. Received a Guaranty Fund Memorandum

Mr. Barlow said that the Life Risk-Based Capital (E) Working Group reviewed the referral regarding adopted amendments to the Life and Health Insurance Guaranty Association Model Act (#520) and determined that no action was necessary to change its current risk charge.

The Task Force accepted the memorandum (Attachment Five).

4. Adopted Proposal 2020-10-CA

Mr. Botsko said proposal 2020-10 (revised Bond Structure for Health and Property/Casualty) was exposed on Oct. 27 for a 45-day comment period ending Dec. 16, 2020, and no comments were received (Attachment Six). Mr. Botsko added that the Health, Life and Property and Casualty Risk-Based Capital (E) Working Groups are continuing to work on their factors and will expose by April 30 for consideration on June 30.

Mr. Chou made a motion, seconded by Mr. Boerner, to adopt proposal 2020-10-CA (Bond Structure-Health and P/C). The motion passed unanimously.

5. Exposed Proposal 2021-02-CA

Mr. Drutz said that the Working Group exposed proposal 2021-02-CA for a 30-day comment period ending March 12, and no comments were received. He said that the purpose of the proposal is to provide clarifying language for the inclusion of incentives in the managed care credit instructions and blank.

Mr. Botsko said the Task Force will expose proposal 2021-02-CA (Managed Care Credit Incentives) (Attachment Seven) for a 30-day comment period ending April 22.

6. Adopted Proposal 2020-08-CR

Mr. Botsko said proposal 2020-08-CR (Clarification to PR027 Interrogatories) is for those insurers that do not report earthquake or hurricane exposure. He said the purpose of this proposal is to clarify the instructions for reporting minimal to no exposure for these catastrophe risks.

Mr. Chou made a motion, seconded by Mr. Boerner, to adopt proposal 2020-08 CR (Clarification to PR027 Interrogatories) (Attachment Eight). The motion passed unanimously.

7. Adopted Proposal 2020-11-CR

Mr. Botsko said the operational risk is now separately addressed in the RBC formula as a stand-alone capital add-on. The purpose of this proposal is to remove the embedded 3% operational risk charge in the Rcat component to avoid double-counting of the charge. He also stated that the Subgroup received comment letters from the American Property Casualty Insurance Association (APCIA) and Reinsurance Association of America (RAA) during the exposure period. They both support this proposal to eliminate the duplicative application of operational risk charges for modeled reinsurance recoverable in the Rcat component.

Mr. Chou made a motion, seconded by Mr. Kupferman, to adopt proposal 2020-11-CR (Remove Operational Risk Factor from Rcat) (Attachment Nine). The motion passed unanimously.

8. Adopted its Working Agenda

Mr. Drutz summarized the changes to the 2021 health RBC working agenda, which included the following substantial changes: 1) the addition to review the managed care credit across the formulas; 2) the deletion of the MAX function as the proposal was adopted for 2021 reporting; and 3) moving the investment income and bond factor items from the New Items section to the Carry Over Items section.

Mr. Botsko summarized the changes to the Working Group’s 2021 working agenda: 1) changed “Evaluate other catastrophe risks for possible inclusion in the charge” item expected completion date to year-end 2022 or later; 2) removed “Evaluate the possibility of using the NAIC as a centralized location for reinsurer designations” and “Evaluate the RBC impact on two different retroactive reinsurance exception approaches”; 3) modified “Evaluate the possibility of allowing additional third-party...
models to calculate the cat model losses” to “Evaluate the possibility of allowing additional third-party models or adjustments to the vendor models to calculate the cat model losses,” and the expected completion date was changed to year-end 2021 or later; and 4) added “Implement Wildfire Peril in the Rcat component (For Informational Purpose Only)” in the new items section.

Mr. Botsko added that the Task Force continues to address the items on its working agenda as they are prioritized and will update the working agenda this summer.

Mr. Drutz made a motion, seconded by Mr. Chou, to adopt the Task Force’s working agenda (Attachment Ten). The motion passed unanimously.

Having no further business, the Capital Adequacy (E) Task Force adjourned.

W:\National Meetings\2021\Spring\TF\CapAdequacy\03_CapitalAdequacyTFmin
The Capital Adequacy (E) Task Force conducted an e-vote that concluded Feb. 1, 2021. The following Task Force members participated: Tynesia Dorsey, Chair, represented by Tom Botisko (OH); Doug Slape, Vice Chair, represented by Mike Boerner (TX); Lori K. Wing-Heir represented by Wally Thomas (AK); Jim L. Ridling (AL); Ricardo Lara represented by Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by Philip Barlow (DC); David Altmaier represented by Virginia Christy (FL); Doug Ommen represented by Mike Yanacheak (IA); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Russell Coy (KY); Chlora Lindley-Myers represented by John Rehagen (MO); Grace Arnold represented by John Robinson (MN); Mike Causey represented by Jackie Obusek (NC); Bruce R. Ramge represented by Lindsay Crawford (NE); Glen Mulfready represented by Andrew Schallhorn (OK); and Mike Kreidler represented by Steve Drutz (WA).

1. Adopted the Updated 2020 U.S. and Non-U.S. Catastrophe Risk Event Lists

The Task Force conducted an e-vote to consider adoption of the updated 2020 U.S. and non-U.S. catastrophe risk event lists.

Mr. Chou made a motion, seconded by Mr. Thomas, to adopt the lists (Attachment One-A). The motion passed unanimously.

Having no further business, the Capital Adequacy (E) Task Force adjourned.
U.S. List of Catastrophes for Use in Reporting catastrophe Data in PR036 and PR100+

| Type of Event   | Name      | Date | Location                                           | Overall losses when occurred |
|----------------|-----------|------|***************************************************|------------------------------|
| Hurricane      | Irene     | 2011 |                                                   | $4,300,000,000               |
| Tropical Storm | Lee       | 2011 |                                                   | $315,000,000                 |
| Hurricane      | Sandy     | 2012 |                                                   | $50,000,000,000              |
| Hurricane      | Isaac     | 2012 |                                                   | $970,000,000                 |
| Tropical Storm | Debby     | 2012 |                                                   | $105,000,000                 |
| Earthquake     |           | 2014 | California                                        | 25+ million                  |
| Hurricane      | Patricia  | 2015 |                                                   | 25+ million                  |
| Hurricane      | Joaquin   | 2015 |                                                   | 25+ million                  |
| Hurricane      | Matthew   | 2016 | Florida, North Carolina, South Carolina, Georgia and Virginia | $2,698,400,000              |
| Hurricane      | Hermine   | 2016 | Florida, North Carolina, South Carolina, Georgia and Virginia | $245,640,000               |
| Hurricane      | Harvey    | 2017 | Texas, Louisiana                                  | 25+ million                  |
| Hurricane      | Jose      | 2017 | East Coast of the United States                   | 25+ million                  |
| Hurricane      | Irma      | 2017 | Eastern United States                             | 25+ million                  |
| Hurricane      | Maria     | 2017 | Southeastern United States, Mid-Atlantic States   | 25+ million                  |
| Hurricane      | Nate      | 2017 | Louisiana, Mississippi, Alabama, Tennessee and Eastern United States | 25+ million                  |
| Tropical Storm | Alberto   | 2018 | Southeast, Midwest                                | 25+ million                  |
| Hurricane      | Lane      | 2018 | Hawaii                                            | 25+ million                  |
| Tropical Storm | Gordon    | 2018 | Southeast, Gulf coast of the United States, Arkansas and Missouri | 25+ million                  |
| Hurricane      | Florence  | 2018 | Southeast, Mid-Atlantic                           | 25+ million                  |
| Hurricane      | Michael   | 2018 | Southeastern and East Coasts of United States     | 25+ million                  |
| Hurricane      | Dorian    | 2019 | Southeast, Mid-Atlantic                           | 500+ million                 |
| Hurricane      | Barry     | 2019 | Southeast, Midwest, Northeast                     | 300+ million                 |
| Tropical Storm | Imelda    | 2019 | Plains, Southeast                                 | 25+ million                  |
| Tropical Storm | Nestor    | 2019 | Southeast                                         | 25+ million                  |
| Hurricane      | Lorenzo   | 2019 | Louisiana, Mississippi, Texas and Arkansas        | 25+ million                  |
| Tropical Storm | Cristobal | 2020 | Southeast, Plains, Midwest                         | 150 million                  |
| Tropical Storm | Fay       | 2020 | Southeast, Northeast                              | 400 million                  |
| Hurricane      | Hanna     | 2020 | Texas                                             | 350 million                  |
| Hurricane      | Issias    | 2020 | Southeast, Mid-Atlantic, Northeast                | > 3 billion                  |
| Hurricane      | Laura     | 2020 | Plains, Southeast, Mid-Atlantic                   | > 4 billion                  |
| Hurricane      | Sally     | 2020 | Southeast (Alabama, Mississippi, Louisiana)       | > 1 billion                  |
| Tropical Storm | Beta      | 2020 | Plains, Southeast                                 | 25+ million                  |
| Hurricane      | Delta     | 2020 | Gulf Coast of United States, Southeast (AL, GA, NC, SC, MS, LA, TX) | > 2 billion                  |
| Hurricane      | Zeta      | 2020 | Gulf coast of the United States, Southeastern United States, Mid-Atlantic | > 1.5 billion               |

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<th>Munich Re NatCATService Insured losses (in original values, US$m)</th>
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<td>05/11/17</td>
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<td>07/29/17</td>
<td>07/31/17</td>
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<td>08/08/17</td>
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<td>08/23/17</td>
<td>08/24/17</td>
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<td>08/27/17</td>
<td>Hurricane Harvey</td>
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<td>08/30/17</td>
<td>08/31/17</td>
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<td>09/06/17</td>
<td>Hurricane Jose</td>
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<td>10/03/17</td>
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<td>Caribbean Islands, UK, France and Spain</td>
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<td>09/19/17</td>
<td></td>
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<td>09/22/17</td>
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<td>Hurricane Nate</td>
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<td>02/09/18</td>
<td>02/20/18</td>
<td>CY Gita</td>
<td>Tonga, Fiji, Samoa, New Zealand</td>
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<td>03/17/18</td>
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<td>05/23/18</td>
<td>05/27/18</td>
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<td>06/02/18</td>
<td>06/07/18</td>
<td>Tropical Storm Ewekari</td>
<td>Vietnam, China, Taiwan, Philippines and Ryukyu Islands</td>
<td>Guangdong Province, Jiangxi, Fujian, Zhejiang Provinces, and Hainan Island, &gt; 25 million</td>
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<td>Earthquake</td>
<td>06/18/18</td>
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<td>Super Typhoon</td>
<td>07/10/18</td>
<td>07/12/18</td>
<td>STY Maria</td>
<td>China, Taiwan, Guam and Japan</td>
<td>Fujian province, Yarbo River Basin, Japan's Ryukyu Islands</td>
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<td>Tropical Storm</td>
<td>07/17/18</td>
<td>07/24/18</td>
<td>TS Sorth-Tinh</td>
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<td>Japan, Russian Far East</td>
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<td>07/22/18</td>
<td>07/25/15</td>
<td>TS Ampil</td>
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<td>08/03/18</td>
<td>TY Jongdari</td>
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<td>08/09/18</td>
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<td>08/18/18</td>
<td>TY Rumbia</td>
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<td>2018</td>
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<td>08/23/18</td>
<td>08/25/18</td>
<td>TY Souik</td>
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<td>Haenam County, South Jeolla Province</td>
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<td>09/04/18</td>
<td>09/05/18</td>
<td>RY Jabi</td>
<td>Japan, Mariana Islands, Taiwan, Japan, Russian Far East and Arct</td>
<td>&gt; 25 million</td>
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<tr>
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<td>09/06/18</td>
<td>Hokkaido</td>
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<td>Super Typhoon</td>
<td>09/15/18</td>
<td>N. Mariana Islands, Philippines, China and Hong Kong</td>
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<td>08/23/18</td>
<td>Azores, Bermuda, Europe</td>
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<td>10/07/18</td>
<td>Central American, Yucatan Peninsula, Cayman Islands, Cuba, Atlantic, Canada</td>
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<td>09/06/18</td>
<td>China</td>
<td>&gt; 25 million</td>
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<tr>
<td>2018</td>
<td>Typhoon</td>
<td>09/15/18</td>
<td>Japan</td>
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<td>08/31/18</td>
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<td>09/05/19</td>
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<td>09/03/19</td>
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<td>09/19/19</td>
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<td>09/23/19</td>
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<td>11/26/19</td>
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<td>11/08/19</td>
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<td>12/18/19</td>
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<td>03/22/20</td>
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<td>Hurricane Humberto</td>
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<td>Hurricane Lorenzo</td>
<td>09/23/19</td>
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<td>11/11/19</td>
<td>India, Bangladesh</td>
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<td>10/02/19</td>
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<td>Earthquake</td>
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<td>01/01/20</td>
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<td>05/01/20</td>
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<td>2020</td>
<td>Tropical Storm</td>
<td>08/02/20</td>
<td>Tropical Storm Nearga</td>
<td>&gt; 25+ million</td>
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<td>----------</td>
<td>----------</td>
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<tr>
<td>2020</td>
<td>Hurricane</td>
<td>11/14/20</td>
<td>11/19/20</td>
<td>ABC Islands, Colombia, Jamaica, Central America</td>
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<td>11/08/20</td>
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<td>Philippines, Vietnam, Laos, Thailand</td>
<td>&gt; 400+ million</td>
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</table>

Source: Munich Re's NAT CAT Service, Swiss Re Sigma and Aon Benfield
The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met March 17, 2021. The following Working Group members participated: Steve Drutz, Chair (WA); Jennifer Li (AL); Wanchin Chou (CT); Carolyn Morgan (FL); Tish Becker (KS); Rhonda Ahrens (NE); Tom Dudek (NY); Kimberly Rankin (PA); and Aaron Hodges (TX).

1. **Adopted its Feb. 10, 2021; Jan. 22, 2021; and Dec. 18, 2020 Minutes**

   The Working Group met Feb. 10, 2021; Jan. 22, 2021; and Dec. 18, 2020. During these meetings, the Working Group took the following action: 1) received, exposed and discussed the American Academy of Actuaries (Academy) report on the inclusion of investment income in the underwriting risk component and impact analysis; 2) discussed its March 5 regulator-to-regulator meeting; 3) referred the health care receivable proposal to the Blanks (E) Working Group for consideration in 2021 reporting; 4) exposed proposal 2021-02-CA (Managed Care Credit – Incentives); 4) received an update on the bond factor analysis; and 5) received a summary of the Blanks (E) Working Group’s proposal related to health business reporting and discussed next steps for the Health Test Ad Hoc Group.

   Mr. Chou made a motion, seconded by Mr. Dudek, to adopt the Working Group’s Feb. 10, 2021 (Attachment Two-A); Jan. 22, 2021 (Attachment Two-B); and Dec. 18, 2020 minutes (Attachment Two-C). The motion passed unanimously.

2. **Adopted its 2021 Working Agenda**

   Mr. Drutz summarized the changes to the 2021 health risk-based capital (RBC) working agenda, which included the following substantial changes: 1) the addition to review the managed care credit across the formulas; 2) the deletion of the MAX function as the proposal was adopted for 2021 reporting; and 3) moving the investment income and bond factor items from the New Items section to the Carry Over Items section.

   Mr. Chou made a motion, seconded by Ms. Rankin, to adopt the 2021 health RBC working agenda (see NAIC Proceedings – Spring 2021, Capital Adequacy (E) Task Force, Attachment Ten). The motion passed unanimously.

3. **Referred Proposal 2021-02-CA to the Capital Adequacy (E) Task Force for Exposure**

   Mr. Drutz said that the Working Group exposed proposal 2021-02-CA for a 30-day comment period ending March 12, and no comments were received. He said that the purpose of the proposal is to provide clarifying language for the inclusion of incentives in the managed care credit instructions and blank.

   Hearing no objections, the Working Group referred proposal 2021-02-CA to the Capital Adequacy (E) Task Force for exposure on all lines of business.

4. **Heard an Update from the Academy on Investment Income in the Underwriting Risk Component and Exposed Proposal 2021-04-CA**

   Mr. Drutz said the Working Group requested the Academy’s assistance in developing adjusted factors to include investment income for Columns 1–4 on the Experience Fluctuation Risk page. The Academy provided the adjusted factors in its letter dated Feb. 22, 2021 (Attachment Two-D). Derek Skoog (Academy) said that the Academy used the same methodology used in its previous letter where the Academy had deconstructed the current factors assuming that they currently have no investment income attributed to them based on its understanding of how they were developed. Then using a combination of the Academy’s knowledge of industry completion factors by product as well as industry loss ratios, the Academy developed a range of potential output risk factors that would correspond to those assumptions. Mr. Skoog said when it comes to determining the investment return rate, there are a number of factors worthy of consideration, and the Academy has included a range of potential results within its letter.

   Mr. Drutz said that a summary (Attachment Two-E) of the number of companies whose RBC ratio changed by both the percentage change and point change for the 0.5%, 1%, 1.5% and 2% investment returns was included in the impact analysis.
He said that a majority of companies had a 0% to 1.5% percent change with the 0.5% investment return, while a majority of companies had about a 0% to 2.5% change in the 1% investment return, a 0% to 3% change with the 1.5% investment return, and 0% to 3.5% change with the 2% investment return.

Mr. Drutz said that the Working Group will need to determine the frequency in which the factors will need to be reviewed and if a benchmark should be established in updating the factors, such as Treasury bonds. He said the five-year Treasury Bond yield for 2021 has ranged from 0.36 to 0.84%, and five years would seem to be the longest time frame to consider based on his understanding of the health portfolios with an average maturity around five years. Mr. Drutz said that proposal 2021-04-CA includes the 0.5% and 1% investment return adjustment to the underwriting risk factors as Option 1 and Option 2.

Hearing no objections, the Working Group agreed to expose proposal 2021-04-CA (Attachment Two-F) for a 30-day public comment period ending April 16. The exposure will include both the 0.5% and 1% investment return factors and the Academy’s Feb. 22 letter. Following the initial exposure, the proposal will then be referred to the Capital Adequacy (E) Task Force for a subsequent exposure for all lines of business.

5. Received an Update on the Bond Factor Impact Analysis

Mr. Drutz said NAIC staff are working on the impact analysis for the 20 designation bond factors based on year-end 2020 reporting. He said the Working Group expects to meet in early April to discuss the results for both the two- and five-year time horizon factors. He said the Working Group will need to determine which factors to move forward with and expose by no later than April 30.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.
The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Feb. 10, 2021. The following Working Group members participated: Steve Drutz, Chair (WA); Steve Ostlund and Jennifer Li (AL); Rolf Kaumann and Eric Unger (CO); Wanchin Chou, Kathy Belfi and Andrew Greenhalgh (CT); Kyle Collins (FL); Tish Becker (KS); Rhonda Ahrens and Michael Muldoon (NE); Tom Dudek (NY); Kimberly Rankin (PA); and Matthew Richard, Aaron Hodges, Sean Fulton and Mike Boerner (TX).

1. Discussed Impact Analysis on Investment Income in Underwriting Risk

Mr. Drutz said the Working Group agreed start working on the impact analysis for the investment income adjustment in the underwriting risk factors for Comprehensive Medical, Medicare Supplement, Dental and Vision, and Stand-Alone Medicare Part D lines of business reported on page XR012. He said the Working Group will continue to work with the American Academy of Actuaries (Academy) to review the remaining lines of business once the initial lines of business have been addressed. He said the key assumptions to consider in determining the investment return are asset duration and spread. He noted that the Academy referenced one-month U.S. treasury yields, and these could be used as a reference point; UnitedHealth Group (UHG) suggested that the rate of investment return be consistent with the time horizon used for the bond risk modeling. He asked if the UHG’s reference to the rate of investment return was referencing the reference rate to be used, the period over which the return should be calculated, or both. Jim Braue (UHG) said it primarily referenced the reference rate, but it could be both because they are interconnected.

Mr. Drutz said the Working Group will be performing an impact analysis on the bond factors using a two- and five-year time horizon, and one of the key questions that the Working Group will have to address is if the duration between the bonds and investment income in the underwriting risk factors should be linked. Derek Skoog (Academy) said the Academy did not necessarily take a position as far as the duration of the assets, but rather the Academy modeled out a month of premiums and claims for simplicity; however, the investment income would be the same if you were modeling out a full contact year. He said the data point for consideration is the average length of time it took to pay out claims, which was approximately one month. The Academy then referenced the one-month treasury yield, which is fairly low, and that was a consideration for the investment return assumption. Mr. Skoog said the critical assumption is the investment return. How you get to that investment return is going to be the product of the duration of the asset and the risk of the asset that was assumed. Treasury yields would be lower than corporate bonds, which would be somewhat higher. Mr. Skoog said the Academy did not take a position on those two points, but that is what drives the investment return assumption. Mr. Drutz noted that the table in the Academy’s letter included the yield assumption and the adjustment that would be based on that yield. He said if the yield were based on a five-year treasury, yielding 0.5% versus a two-year corporate bond that was yielding 0.5%, the adjustments to the risk factors would not change based on the length of the duration of the bonds. Mr. Skoog agreed. Mr. Drutz said that adjustment to the factors is not based on duration.

Mr. Drutz asked the Working Group to consider what rate should be used. He said three-month Treasury yields are at 0.04% and five-year yields are at about 0.46%. He said there appears to be a linear relationship between the yield and the reduction in the risk factor. Mr. Boerner suggested a granular stair step approach using the 0.5%, 1%, 1.5% and 2% returns in the impact analysis. Mr. Dudek agreed with using the four points to show more of the stair step method. Lou Felice (NAIC) said the investment returns appear to be the outer markers, and the 0% is essentially a one-month Treasury yield up to something like a two- to three-year investment grade corporate bond. He asked if the 2–3% investment return is about where a two- to three-year corporate return is today. Edward Toy (Risk & Regulatory Consulting LLC) said corporate “A” rated yields are about 1.66%, and “BBB” corporates are just over 2%.

Mr. Drutz said the Working Group will also need to consider if there is a certain reference rate when making the assumptions on the investment yields. For example, should the Working Group look at “A” rated corporate bond yields over five- or two-year periods or should it be treasuries or a mix of both. Mr. Drutz said the Working Group will also need to consider the frequency of the adjustment, and he suggested setting a benchmark to determine what assumptions to use. He said as an example, if the adjustment was based on a corporate five-year yield, the Working Group could then review that number annually and adjust the risk charge based on whether that return is going up or down. He said if the benchmark linked to a particular rate of return, it would be helpful in making decisions on the adjustment to the factors in the coming years.
The Working Group agreed to run the impact analysis on a half point basis from 0.5% up to 2%.

2. Exposed Proposal 2021-02-CA

Mr. Drutz said NAIC staff drafted proposal 2021-02-CA, which clarifies and includes a reference for “incentives” where “withholds and bonuses” are referenced in the Managed Care Credit instructions. A definition was also included in Appendix 1 for “Incentives, Bonuses and Withholds.” Mr. Drutz said the following questions need to be considered: 1) whether there is a consistent use of incentives, where a set amount is paid; and 2) whether there are scenarios in which incentives could be classified or the payment is built into the claim payment. Mr. Felice said NAIC staff received a question related to what gets included in some of the managed care credit lines calculation for category 2. He said the question was focused on the line in that category, which says to report net of withholds; in other words, this means the full amount of the claim before adjustment for the withhold and also net of bonuses, which means that if there is a bonus that was paid out, it would show the amount of the claims that were paid without including the bonus. He asked what to do with incentives. In the past, incentives were normally paid out after the actual claim was paid, it would be included like a bonus or withhold, and the value of the claim would be reported without consideration of those items on that line. However, there are some items, mostly in government programs, that are called incentives where the incentive is built into the value of the claim. The claim is then paid at an increased value to encourage things like getting a doctor to participate in an underserved area or to help a doctor with the International Classification of Diseases (ICD) 10 in a small office to upgrade their abilities to share or report claims data and medical information. In most cases, these would be reported like a bonus and withhold arrangements because they were called incentive pools—pools of money set aside to, not dissimilar to a bonus arrangement and paid after the claim. However, if there are instances where the claim is enhanced and that is considered an incentive arrangement, we want to be sure that we instruct this to be reported properly. Mr. Felice asked industry users who see these arrangements every day whether there are arrangements with no distinction between the claim value and the incentive because it is paid under a contractual arrangement.

Hearing no objections, proposal 2021-02-CA (Attachment Two-A1) was exposed for a 30-day public comment period ending March 12. Following the initial exposure, the proposal will then be referred to the Capital Adequacy (E) Task Force for a subsequent exposure for all lines of business.

3. Discuss Bond Factor Analysis

Mr. Drutz said the Working Group agreed to perform an impact analysis on the two- and five-year time horizon factors for the 20 bond designations for year-end 2020; and while a majority of states have a March 1 annual statement filing deadline, there are a few states that have a March 31 or April 1 filing deadline. He recommended that the companies with a March 1 filing deadline be included in the impact analysis to ensure that the April 30 exposure deadline can be met. Mr. Ostlund asked how many companies do not have the March 1 filing deadline. Crystal Brown (NAIC) said she would identify the states with the March 31 and April 1 filing dates and the number of companies that would not file until that date, and she will bring this information back to the Working Group.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.

W:\National Meetings\2021\Spring\TF\Capadequacy\Healthrbc\Proceedings\Att2A_02_10_21_HRBC Minutes.Docx
** Capital Adequacy (E) Task Force **

**RBC Proposal Form**

| [ ] Catastrophe Risk (E) Subgroup | [ ] Investment RBC (E) Working Group | [ ] Longevity Risk (A/E) Subgroup |
| [ ] C3 Phase II/ AG43 (E/A) Subgroup | [ ] P/C RBC (E) Working Group |

**DATE:** 1-28-21

**CONTACT PERSON:** Crystal Brown

**TELEPHONE:** 816-783-8146

**EMAIL ADDRESS:** cbrown@naic.org

**ON BEHALF OF:** Health RBC (E) Working Group

**NAME:** Steve Drutz

**TITLE:** Chief Financial Analyst/Chair

**AFFILIATION:** WA Office of Insurance Commissioner

**ADDRESS:** PO Box 40255

Olympia, WA 98504-0255

**FOR NAIC USE ONLY**

Agenda Item # 2021-02-CA

**DISPOSITION**

[ ] ADOPTED

[ ] REJECTED

[ ] DEFERRED TO

[ ] REFERRED TO OTHER NAIC GROUP

[ ] EXPOSED

[ ] OTHER (SPECIFY)

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

[ x ] Health RBC Blanks

[ x ] Property/Casualty RBC Blanks

[ x ] Life and Fraternal RBC Instructions

[ x ] Health RBC Instructions

[ x ] Property/Casualty RBC Instructions

[ x ] Life and Fraternal RBC Blanks

[ ] OTHER ____________________________

**DESCRIPTION OF CHANGE(S)**

Incorporate references for “Incentives” under the managed care instructions and blank as “Bonuses/Incentives.”

**REASON OR JUSTIFICATION FOR CHANGE **

Currently the managed care instructions and blank only reference the bonuses, this change would clarify that both incentives and bonuses are to be included.

**Additional Staff Comments:**

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# Health

## UNDERWRITING RISK - Managed Care Credit Calculation

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<th>Managed Care Claims Payments</th>
<th>Annual Statement Source</th>
<th>Factor</th>
<th>Paid Claims</th>
<th>Weighted Claims†</th>
<th>Part D Weighted Claims‡</th>
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### Stand-Alone Medicare Part D Coverage Claim Payments

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<td>(15) Total Paid Claims</td>
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### Weighted Average Managed Care Discount

(16) Weighted Average Managed Care Discount

(17) Weighted Average Managed Care Risk Adjustment Factor

† This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental/Vision Managed Care Discount factor.

‡ This column is for the Medicare Part D Managed Care Discount factor.

§ Stand-Alone Medicare Part D business reported in Lines (12) and (13) would be excluded from these amounts.

* The factor is calculated on page XR018.

Denotes items that must be manually entered on filing software.
### Calculation of Category 2 Managed Care Factor

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<td>MCC Multiplier - Average Withhold Returned [Line (18)/(19)]</td>
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<td>Withholds &amp; Bonuses/Incentives Available, <em>Prior Year</em></td>
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<td>Claims Payments Subject to Withhold, <em>Prior Year</em></td>
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<td>Average Withhold Rate, <em>Prior Year</em> [Line (21)/(22)]</td>
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<tr>
<td>24</td>
<td>MCC Discount Factor, Category 2 [\text{Min}{.25,\text{Lines (20) x (23)}}]</td>
<td>Company Records</td>
<td></td>
</tr>
</tbody>
</table>

* The factor is pulled into Lines (3) and (4) on page XR017.

Denotes items that must be manually entered on filing software.
## UNDERWRITING RISK – MANAGED CARE CREDIT

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Annual Statement Source</th>
<th>Paid Claims</th>
<th>Factor</th>
<th>Weighted Claims*</th>
<th>Weighted Claims**</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>Category 0 - Arrangements not Included in Other Categories</td>
<td>Company records</td>
<td>X</td>
<td>0.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>Category 1 - Payments Made According to Contractual Arrangements</td>
<td>Company records</td>
<td>X</td>
<td>0.150</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3)</td>
<td>Category 2a - Subject to Withholds or Bonuses</td>
<td>Incentives – Otherwise Category 0</td>
<td>Company records</td>
<td>X  †</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4)</td>
<td>Category 2b - Subject to Withholds or Bonuses</td>
<td>Incentives – Otherwise Category 1</td>
<td>Company records</td>
<td>X ‡</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5)</td>
<td>Category 3a - Capitated Payments Directly to Providers</td>
<td>Company records</td>
<td>X</td>
<td>0.600</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6)</td>
<td>Category 3b - Capitated Payments to Regulated Intermediaries</td>
<td>Company records</td>
<td>X</td>
<td>0.600</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(7)</td>
<td>Category 3c - Capitated Payments to Non-Regulated Intermediaries</td>
<td>Company records</td>
<td>X</td>
<td>0.600</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8)</td>
<td>Category 4 - Medical &amp; Hospital Expense Paid as Salary to Providers</td>
<td>Company records</td>
<td>X</td>
<td>0.750</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Subtotal Paid Claims | Sum of Lines (1) through (8) |

### Stand-Alone Medicare Part D Coverage Claim Payments

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Annual Statement Source</th>
<th>Paid Claims</th>
<th>Factor</th>
<th>Weighted Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>(10)</td>
<td>Category 0 - No Federal Reinsurance or Risk Corridor Protection</td>
<td>Company records</td>
<td>XXX</td>
<td>X</td>
<td>xxx</td>
</tr>
<tr>
<td>(11)</td>
<td>Category 1 - Federal Reinsurance but no Risk Corridor Protection</td>
<td>Company records</td>
<td>XXX</td>
<td>X</td>
<td>xxx</td>
</tr>
<tr>
<td>(12)</td>
<td>Category 2a - No Federal Reinsurance but Risk Corridor Protection</td>
<td>Company records</td>
<td>X</td>
<td>0.667</td>
<td></td>
</tr>
<tr>
<td>(13)</td>
<td>Category 3a - Federal Reinsurance and Risk Corridor Protection apply</td>
<td>Company records</td>
<td>X</td>
<td>0.767</td>
<td></td>
</tr>
</tbody>
</table>

| Subtotal Stand-Alone Medicare Part D Paid Claims | Sum of Lines (10) through (13) |

| Total Paid Claims | Line (9) + Line (14) |

<table>
<thead>
<tr>
<th>Weighted Average Managed Care Discount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column (3) – Column (3)</td>
</tr>
<tr>
<td>Line (9) / Column (2) Line (9)</td>
</tr>
<tr>
<td>Column (4) – Column (4)</td>
</tr>
<tr>
<td>Line (14) / Column (2) Line (14)</td>
</tr>
</tbody>
</table>

| Weighted Average Managed Care Risk Adjustment Factor | 1.0 - Line (16) |

### Calculation of Category 2 Managed Care Factor (Comprehensive Medical and Dental only) | Amount |

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Annual Statement Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(18)</td>
<td>Withhold &amp; bonus/incentive payments, prior year</td>
<td>Company Records</td>
<td></td>
</tr>
<tr>
<td>(19)</td>
<td>Withhold &amp; bonuses/incentives available, prior year</td>
<td>Company Records</td>
<td></td>
</tr>
<tr>
<td>(20)</td>
<td>Managed Care Credit Multiplier – average withhold returned</td>
<td>Line (18) / Line (19)</td>
<td></td>
</tr>
<tr>
<td>(21)</td>
<td>Withholds &amp; bonuses/incentives available, prior year</td>
<td>Line (19)</td>
<td></td>
</tr>
<tr>
<td>(22)</td>
<td>Claims payments subject to withhold, prior year</td>
<td>Company Records</td>
<td></td>
</tr>
<tr>
<td>(23)</td>
<td>Average withhold rate, prior year</td>
<td>Line (21) / Line (22)</td>
<td></td>
</tr>
<tr>
<td>(24)</td>
<td>Managed Care Credit Discount Factor, Category 2</td>
<td>Minimum of 0.25 or</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Line (20) x Line (23)</td>
<td></td>
</tr>
</tbody>
</table>

† Category 2 Managed Care Factor calculated on Line (24) with a minimum factor of 15 percent.
‡ Category 2 Managed Care Factor calculated on Line (24) with a minimum factor of 15 percent.
* This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental managed care discount factor.
** This column is for the Stand-Alone Medicare Part D managed care discount factor.

Denotes items that must be manually entered on the filing software.
<table>
<thead>
<tr>
<th>Comprehensive Medical, Medicare Supplement and Dental &amp; Vision</th>
<th>Annual Statement Source</th>
<th>Paid Claims</th>
<th>Factor</th>
<th>Weighted Claims†</th>
<th>Weighted Claims‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Category 0 - Arrangements not Included in Other Categories</td>
<td>Company records</td>
<td>0</td>
<td>0.000</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(2) Category 1 - Payments Made According to Contractual Arrangements</td>
<td>Company records</td>
<td>0</td>
<td>0.150</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(3) Category 2a - Subject to withholds or Bonuses/Incentives - Otherwise Category 1</td>
<td>Company records</td>
<td>0</td>
<td>*</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(4) Category 2b - Subject to withholds or Bonuses/Incentives - Otherwise Category 1</td>
<td>Company records</td>
<td>0</td>
<td>**</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(5) Category 3a - Capitated Payments Directly to Providers</td>
<td>Company records</td>
<td>0</td>
<td>0.600</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(6) Category 3b - Capitated Payments to Regulated Intermediaries</td>
<td>Company records</td>
<td>0</td>
<td>0.600</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(7) Category 3c - Capitated Payments to Non-Regulated Intermediaries</td>
<td>Company records</td>
<td>0</td>
<td>0.600</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(8) Category 4 - Medical &amp; Hospital Expense Paid as Salary to Providers</td>
<td>Company records</td>
<td>0</td>
<td>0.750</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(9) Sub-Total Paid Claims</td>
<td>Sum of Lines (1) through (8)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stand-Alone Medicare Part D Coverage Claim Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>(10.1) Category 0 - No Federal Reinsurance or Risk Corridor Protection</td>
</tr>
<tr>
<td>(10.2) Category 1 - Federal Reinsurance but no Risk Corridor Protection</td>
</tr>
<tr>
<td>(10.3) Category 2a - No Federal Reinsurance but Risk Corridor Protection</td>
</tr>
<tr>
<td>(10.4) Category 3a - Federal Reinsurance and Risk Corridor Protection apply</td>
</tr>
<tr>
<td>(10.5) Sub-Total Paid Claims</td>
</tr>
<tr>
<td>(10.6) Total Paid Claims</td>
</tr>
<tr>
<td>(11) Weighted Average Managed Care Discount</td>
</tr>
<tr>
<td>(12) Weighted Average Managed Care Risk Adjustment Factor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calculation of Category 2 Managed Care Factor</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(13) Withhold &amp; bonus/Incentive payments, prior year</td>
<td>Company Records</td>
</tr>
<tr>
<td>(14) Withhold &amp; bonus/Incentive payments, available, prior year</td>
<td>Company Records</td>
</tr>
<tr>
<td>(15) Managed Care Credit Multiplier – average withhold returned</td>
<td>Line (13) / Line (14)</td>
</tr>
<tr>
<td>(16) Withholds &amp; bonuses/Incentives available, prior year</td>
<td>Line (14)</td>
</tr>
<tr>
<td>(17) Claims payments subject to withhold, prior year</td>
<td>Company Records</td>
</tr>
<tr>
<td>(18) Average withhold rate, prior year</td>
<td>Line (16) / Line (17)</td>
</tr>
<tr>
<td>(19) Managed Care Credit Discount Factor, Category 2</td>
<td>Minimum of 0.25 or Line (15) x Line (18)</td>
</tr>
</tbody>
</table>

* Category 2 Managed Care Factor calculated on Line (19)
** Category 2 Managed Care Factor calculated on Line (19) with a minimum factor of 15 percent.
† This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental managed care discount factor.
‡ This column is for the Stand-Alone Medicare Part D managed care discount factor.

Denotes items that must be manually entered on the filing software.
The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between health entities and pure indemnity carriers. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claim payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

There are currently five levels of managed care that are used in the formula, other than for Medicare Part D Coverage, although in the future as new managed care arrangements evolve, the number of categories may increase, or new arrangements may be added to the existing categories. The managed care categories are:

* Category 0 – Arrangements not Included in Other Categories
* Category 1 – Contractual Fee Payments
* Category 2 – Bonus and/or Incentives / Withhold Arrangements
* Category 3 – Capitation
* Category 4 – Non-Contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements

For Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Lines (10) through (13) will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future, no other managed care credits are allowed for this coverage.

The managed care credit is based on the percentage of paid claims that fall into each of these categories. Total claim payments are allocated among these managed care categories based on the variability of reserves (unpaid claims) in incurred claim amounts and the difficulty in allocating reserves (unpaid claims) by managed care category.

In some instances, claim payments may fit into more than one category. If that occurs, enter the claim payments into the highest applicable category. CLAIM PAYMENTS CAN ONLY BE ENTERED INTO ONE OF THESE CATEGORIES! The total of the claim payments reported in the Managed Care Credit Calculation page should equal the total year's paid claims.

**Line (1) – Category 0 – Arrangements not Included in Other Categories:** There is a zero managed care credit for claim payments in this category, which includes:

- Fee for service (charges).
- Discounted FFS (based upon charges).
- Usual Customary and Reasonable (UCR) Schedules.
- Relative Value Scales (RVS) where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less.
- Stop loss payments by a health entity to its providers that are capitated or subject to withhold incentive programs.
- Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withholds later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement).
- Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).
This amount should equal Exhibit 7, Part 1, Column 1, Line 5 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

**Line (2) – Category 1 – Payments Made According to Contractual Arrangements.** There is a 15 percent managed care credit for payments included in this category:

- Hospital per diems, DRGs or other hospital case rates.
- Non-adjustable professional case and global rates.
- Provider fee schedules.
- RVS where the payment base and RV factor are fixed by contract for more than one year.
- Ambulatory payment classifications (APCs).

This amount should equal Exhibit 7, Part 1, Column 1, Line 6 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

**Line (3) - Category 2a - Payments Made Subject to Withholds or Bonuses/Incentives With No Other Managed Care Arrangements.** This category may include business that would have otherwise fit into Category 0. That is, there may be a bonus/incentives/withhold arrangement with a provider who is reimbursed based on a UCR schedule (Category 0).

The maximum Category 2a managed care credit is 25 percent. The credit is based upon a calculation that determines the ratio of withholds returned and bonuses and incentives paid to providers during the prior year to total withholds and bonuses and incentives available to the providers during that year. That ratio is then multiplied by the average provider withhold ratio for the prior year to determine the current year’s Category 2a managed care credit factor. Bonus and incentive payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to the result of the following calculation:

**EXAMPLE – 2019 Reporting Year**

| 2018 withhold / bonus/incentive payments | 750,000 |
| 2018 withholds / bonuses/incentives available | 1,000,000 |
| A. MCC Factor Multiplier | 75% – Eligible for credit |
| 2018 withhold / bonuses/incentives available | 1,000,000 |
| 2018 claims subject to withhold - gross* | 5,000,000 |
| B. Average Withhold Rate | 20% |
| Category 2 Managed Care Credit Factor (A x B) | 15% |

The resulting factor is multiplied by claim payments subject to withhold - net** in the current year.

* These are amounts due before deducting withhold or paying bonuses and/or incentives.

** These are actual payments made after deducting withhold or paying bonuses and/or incentives.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives, but otherwise had no managed care arrangements. This amount should equal Exhibit 7, Part 1, Column 1, Line 7 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).
Line (4) – Category 2b – Payments Made Subject to Withholds or Bonuses/Incentives That Are Otherwise Managed Care Category 1. Category 2b may include business that would have otherwise fit into Category 1. That is, there may be a bonus/incentives/withhold arrangement with a provider who is reimbursed based on a provider fee schedule (Category 1). The Category 2 discount for claim payments that would otherwise qualify for Category 1 is the greater of the Category 1 factor or the calculated Category 2 factor.

The maximum Category 2b managed care credit is 25 percent. The minimum of Category 2b managed care credit is 15 percent (Category 1 credit factor). The credit calculation is the same as found in the previous example for Category 2a.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives AND where the payments were made according to one of the contractual arrangements listed for Category 1. This amount should equal Exhibit 7, Part 1, Column 1, Line 8 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (5) – Category 3a – Capitated Payments Directly to Providers. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitation or percent of premium payments directly to licensed providers.

Enter the amount of claim payments paid DIRECTLY to licensed providers on a capitated basis. This amount should equal Exhibit 7, Part 1, Column 1, Line 1 + Line 3 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (6) – Category 3b – Capitated Payments to Regulated Intermediaries. There is a managed care credit of 60 percent for claim payments in this category, which includes:

- All capitation or percent of premium payments to intermediaries that in turn pay licensed providers.

Enter the amount of medical expense capitations paid to regulated intermediaries. An intermediary is a person, corporation or other business entity (not licensed as a medical provider) that arranges, by contracts with physicians and other licensed medical providers, to deliver health services for a health entity and its enrollees via a separate contract between the intermediary and the health entity. This includes affiliates of a health entity that are not subject to RBC, except in those cases where the health entity qualifies for a higher managed care credit because the capitated affiliate employs providers and pays them non-contingent salaries, and where the affiliated intermediary has a contract only with the affiliated health entity. A Regulated Intermediary is an intermediary (affiliated or not) subject to state regulation and files the Health RBC formula with the state.

Line (7) – Category 3c – Capitated Payments to Non-Regulated Intermediaries. There is a managed care credit of 60 percent for claim payments in this category, which includes:

- All capitation or percent of premium payments to intermediaries that in turn pay licensed providers. (Subject to a 5 percent limitation on payments to providers or other corporations that have no contractual relationship with such intermediary. Amounts greater than the 5 percent limitation should be reported in Category 0.)

Enter the amount of medical expense capitations paid to non-regulated intermediaries.

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under category 1 for a provider, and for an intermediary at the greater of category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive revisions
either within or beyond a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under category 0 for both providers and intermediaries.

Line (8) – Category 4 – Medical & Hospital Expense Paid as Salary to Providers. There is a managed care credit of 75 percent for claim payments in this category. Once claim payments under this managed care category are totaled, any fee for service revenue from uninsured plans (i.e., ASO or ASC) that was included on line 7 in the Underwriting Risk section should be deducted before applying the managed care credit factor. This category includes:

- Non-contingent salaries to persons directly providing care.
- The portion of payments to affiliated entities, which is passed on as non-contingent salaries to persons directly providing care where the entity has a contract only with its affiliated health entity.
- All facilities related medical expenses and other non-provider medical costs generated within a health facility that is owned and operated by the health entity.
- Aggregate cost payments.

Salaries paid to doctors and nurses whose sole corporate purpose is utilization review are also included in this category if such payments are classified as “medical expense” payments (paid claims) rather than administrative expenses. The "aggregate cost" method of reimbursement means where a health plan has a reimbursement plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other users of services, and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, which put their respective capital and surplus at risk in guaranteeing each other.

This amount should equal Exhibit 7, Part 1, Column 1, Line 9 + Line 10 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (9) – Sub-Total Paid Claims. The total of paid claims for Comprehensive Medical, Medicare Supplement and Dental should equal the total claims paid for the year as reported in Exhibit 7, Part 1, Column 1, Line 13 less Line 11 of the annual statement and the sum of Lines (8.3), (12) and (13) on page XR017 – Underwriting Risk – Managed Care Credit.

Line (10) – Category 0 – No Federal Reinsurance or Risk Corridor Protection. Category 0 for Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

Line (11) – Category 1 – Federal Reinsurance but no Risk Corridor Protection. Category 1 for Medicare Part D Coverage would be all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

Line (12) – Category 2a – No Federal Reinsurance but Risk Corridor Protection. Category 2a for Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Line (13) – Category 3a – Federal Reinsurance and Risk Corridor Protection. Category 3a for Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

Line (14) – Sub-Total Paid Claims. The total paid claims for Medicare Part D Coverage, excluding supplemental benefits.

Line (16) – Weighted Average Managed Care Discount. These amounts are calculated by dividing the total weighted claims by the comparable sub-total claim payments. For Column (3), this is Column (3), Line (9) divided by Column (2), Line (9). For Column (4), this is Column (4), Line (14) divided by Column (2), Line (14).
Line (17) – Weighted Average Managed Care Risk Adjustment Factor. These are the credit factors that are carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount values in Line (16).

Lines (18) through (24) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses. This table requires data from the PRIOR YEAR to compute the current year’s discount factor. These do not apply to Medicare Part D coverage.

Line (18) – Withhold & Bonus/Incentive Payments, prior year. Enter the prior year’s actual withhold and bonus/incentive payments.

Line (19) – Withhold & Bonuses/Incentives Available, prior year. Enter the prior year’s withhold and bonuses/incentives that were available for payment in the prior year.

Line (20) – MCC Multiplier – Average Withhold Returned. Divides Line (18) by Line (19) to determine the portion of withholds and bonuses/incentives that were actually returned in the prior year.

Line (21) – Withholds & Bonuses/Incentives Available, prior year. Equal to Line (19) and is automatically pulled forward.

Line (22) – Claims Payments Subject to Withhold, prior year. Claim payments that were subject to withholds and bonuses/incentives in the prior year. Equal to L(3) + L(4) of the managed care credit claims payment table FOR THE PRIOR YEAR.

Line (23) – Average Withhold Rate, prior year. Divides Line (21) by Line (22) to determine the average withhold rate for the prior year.

Line (24) – MCC Discount Factor, Category 2. Multiplies Line (20) by Line (23) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the health entity’s withhold/bonus/incentive program in the prior year.
UNDERWRITING RISK - MANAGED CARE CREDIT
LR022

This worksheet LR022 Underwriting Risk – Managed Care Credit is optional. It may be completed for only part of the comprehensive medical dental business, Stand-Alone Medicare Part D Coverage or all of them. Line (1) will be filled in as the balancing item if any of Lines (2) through (8) are entered (and then Line (9) will be required).

The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between coverages subject to the managed care credit and pure indemnity insurance. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claims payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

There are five levels of managed care that are used in the RBC formulas other than for Stand-Alone Medicare Part D Coverage, although in the future as new managed care arrangements evolve, the number of categories may increase or new arrangements may be added to the existing categories. The managed care categories are:

- Category 0 - Arrangements not Included in Other Categories
- Category 1 - Contractual Fee Payments
- Category 2 – Bonus and/or incentives / Withhold Arrangements
- Category 3 - Capitation
- Category 4 - Non-contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements

For Stand-Alone Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Lines (10) through (13) will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future no other managed care credits are allowed for this coverage.

The managed care credit is based on the percentage of paid claims that fall into each of these categories. Total claims payments are allocated among these managed care “buckets” to determine the weighted average discount, which is then used to reduce the Underwriting Risk-Experience Fluctuation RBC. Paid claims are used instead of incurred claims due to the variability of reserves (unpaid claims) in incurred claim amounts and the difficulty in allocating reserves (unpaid claims) by managed care category.

In some instances, claims payments may fit into more than one category. If that occurs, enter the claims payments into the highest applicable category. CLAIMS PAYMENTS CAN ONLY BE ENTERED INTO ONE OF THESE CATEGORIES! The total of the claims payments reported in the managed care worksheet should equal the total year’s paid claims. Category 2a, Category 2b and Category 3c are not allowed to include non-regulated intermediaries who are affiliated with the reporting company in order to insure that true risk transfer is accomplished.

Line (1)
Category 0 - Arrangements not Included in Other Categories. There is a zero managed care credit for claim payments in this category, which includes:
- Fee for service (charges).
- Discounted fee for service (based upon charges).
- Usual customary and reasonable (UCR) schedules.
- Relative value scale (RVS), where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less.
- Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withholds later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement).
- Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).
- Claim payments not included in other categories.

**Line (2)**

**Category 1 - Payments Made According to Contractual Arrangements.** There is a 15 percent managed care credit for payments included in this category:
- Hospital per diems, diagnostic related groups (DRGs) or other hospital case rates.
- Non-adjustable professional case and global rates.
- Provider fee schedules.
- Relative value scale (RVS), where the payment base and RV factor are fixed by contract for more than one year.

**Line (3)**

**Category 2a - Payments Made Subject to Withholds or Bonuses / Incentives with No Other Managed Care Arrangements.** This category may include business that would have otherwise fit into Category 0. That is, there may be a bonus /incentives /withhold arrangement with a provider who is reimbursed based on a UCR schedule (Category 0).

The maximum Category 2a managed care credit is 25 percent. The credit is based upon a calculation that determines the ratio of withholds returned and bonuses and/or incentives paid to providers during the prior year to total withholds and bonuses and incentives available to the providers during that year. That ratio is then multiplied by the average provider withhold ratio for the prior year to determine the current year’s Category 2a managed care credit factor. Bonus and/or incentive payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to the result of the following calculation:

**EXAMPLE - 1998 Reporting Year**

| 1997 withhold / bonus /incentives available | 1,000,000 |
| 1997 withhold / bonus /incentives paid | 75,000 |
| A. MCC Factor Multiplier | 0.75 - Eligible for credit |
| 1997 withholds / bonuses /incentives available | 1,000,000 |
| 1997 claims subject to withhold - gross† | 500,000 |
| B. Average Withhold Rate | 20% |
| Category 2 Managed Care Credit Factor (A x B) | 15% |

The resulting factor is multiplied by claims payments subject to withhold - net‡ in the current year.

† These are amounts due before deducting withhold or paying bonuses and/or incentives.
‡ These are actual payments made after deducting withhold or paying bonuses and/or incentives.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses and incentives, but otherwise had no managed care arrangements.

**Line (4)**
Category 2b: Payments Made Subject to Withholds or Bonuses/Incentives That Are Otherwise Managed Care Category 1. Category 2b may include business that would have otherwise fit into Category 1. That is, there may be a bonus/incentive withhold arrangement with a provider who is reimbursed based on a provider fee schedule (Category 1). The Category 2 discount for claims payments that would otherwise qualify for Category 1 is the greater of the Category 1 factor or the calculated Category 2 factor.

The maximum Category 2b managed care credit is 25 percent. The minimum of Category 2b managed care credit is 15 percent (Category 1 credit factor). The credit calculation is the same as found in the previous example for Category 2a.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives AND where the payments were made according to one of the contractual arrangements listed for Category 1.

Line (5)
Category 3a: Capitated Payments Directly to Providers. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitation or percent of premium payments directly to licensed providers.

Enter the amount of claims payments paid DIRECTLY to licensed providers on a capitated basis.

Line (6)
Category 3b: Capitated Payments to Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitation or percent of premium payments to regulated intermediaries that, in turn, pay licensed providers.

Enter the amount of medical expense capitations paid to regulated intermediaries (see Appendix 2 for definition). In those cases where the capitated regulated intermediary employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

Line (7)
Category 3c: Capitated Payments to Non-Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitated or percent of premium payments to non-affiliated intermediaries that, in turn, pay licensed providers (subject to a 5 percent limitation on payments to providers or other corporations that have no contractual relationship with such intermediary. Amounts greater than the 5 percent limitation should be reported in Category 0).

Enter the amount of medical expense capitations paid to non-regulated intermediaries not affiliated with the reporting company. Do not include the amount of medical expense capitations paid to non-regulated intermediaries affiliated with the reporting company. These amounts should be reported in Category 0. Non-regulated intermediaries are those organizations that meet the definition in Appendix 2 for Intermediary but not regulated intermediary. In those cases where the capitated non-regulated intermediary (even if affiliated) employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 1 for a provider, and for an intermediary at the greater
of Category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive revisions either within or beyond a 12 month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 0 for both providers and intermediaries.

Line (8)
Category 4 - Medical & Hospital Expense Paid as Salary to Providers. There is a managed care credit of 75 percent for claims payments in this category. Once claims payments under this managed care category are totaled, any fee for service revenue from uninsured plans (i.e., ASO or ASC) that was included on Line (7) in the underwriting risk section should be deducted before applying the managed care credit factor.

- Non-contingent salaries to persons directly providing care.
- The portion of payments to affiliated entities passed on as non-contingent salaries to persons directly providing care where the entity has a contract only with the company.
- All facilities-related medical expenses and other non-provider medical costs generated within health facility that is owned and operated by the insurer.
- Aggregate cost payments.

Salaries paid to doctors and nurses whose sole corporate purpose is utilization review are also included in this category if such payments are classified as “medical expense” payments (paid claims) rather than administrative expenses. The Aggregate Cost method of reimbursement means where a health plan has a reimbursement plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other users of services; and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, which put their respective capital and surplus at risk in guaranteeing each other.

Line (9)
Subtotal Paid Claims – The total of Column (2) paid claims should equal the total claims paid for the year as reported in Schedule H, Part 5, Columns 1 and 2, Line A.4 of the annual statement.

Line (10)
Category 0 for Stand-Alone Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

Line (11)
Category 1 for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

Line (12)
Category 2a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Line (13)
Category 3a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

Line (16)
Weighted Average Managed Care Discount – The amounts in Column (3) and Column (4) are calculated by dividing the total weighted claims in Column (3) by the total claims paid in Column (2) for Lines (9) and (14) respectively.
Weighted Average Managed Care Risk Adjustment Factor – These are the credit factors that are carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount (Line (16)).

Lines (18) through (24)
Lines (18) through (24) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses. This table requires data from the PRIOR YEAR to compute the current year’s discount factor.

Line (18)
Enter the prior year’s actual withhold and bonus payments.

Line (19)
Enter the prior year’s withholds and bonuses that were available for payment in the prior year.

Line (20)
Divides Line (18) by Line (19) to determine the portion of withholds and bonuses that were actually returned in the prior year.

Line (21)
Equal to Line (19) and is automatically pulled forward.

Line (22)
Claims payments that were subject to withholds and bonuses in the prior year. Equal to Line (3) + Line (4) of LR022 Underwriting Risk – Managed Care Credit FOR THE PRIOR YEAR.

Line (23)
Divides Line (21) by Line (22) to determine the average withhold rate for the prior year.

Line (24)
Multiplies Line (20) by Line (23) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the insurer’s withhold/bonus program in the prior year.
This worksheet PR021 Underwriting Risk – Managed Care Credit is optional. It may be completed for only part of the Comprehensive Medical, Stand-Alone Medicare Part D coverage, Dental business or all of them. Line (1) will be filled in as the balancing item if any of Lines (2) through (8) are entered (and then Line (9) will be required).

The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between coverages subject to the managed care credit and pure indemnity insurance. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claims payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

There are currently five levels of managed care that are used in the RBC formulas other than for Stand-Alone Medicare Part D coverage, although in the future as new managed care arrangements evolve, the number of categories may increase or new arrangements may be added to the existing categories. The managed care categories are:

1. Category 0 - Arrangements not Included in Other Categories
   - Fee for service (charges)
   - Discounted fee for service (based upon charges)
   - Usual customary and reasonable (UCR) schedules
   - Relative value scale (RVS) where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less.

2. Category 1 - Contractual Fee Payments
   - Arrangements classified as contractual payments (e.g., capped carve-outs)

3. Category 2 - Bonus and/or Incentives / Withhold Arrangements
   - Arrangements that involve a bonus or incentive payment
   - Arrangements that involve a withhold payment

4. Category 3 - Capitation
   - Arrangements where the payment is based on a fixed amount per member per month

5. Category 4 - Non-contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements
   - Arrangements where the payment is based on a fixed amount per member per month
   - Arrangements that involve an aggregate cost arrangement
   - Arrangements that involve a participation agreement

For Stand-Alone Medicare Part D coverage, the reduction in uncertainty comes from two federal supports: the reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Line (11) will have the following three components:

- Category 0 - Arrangements not Included in Other Categories (Line (11.1))
- Category 1 - Contractual Fee Payments (Line (11.2))
- Category 2 - Bonus and/or Incentives / Withhold Arrangements (Line (11.3))
- Category 3 - Capitation (Line (11.4))
- Category 4 - Non-contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements (Line (11.5))
- Category 5 - Other Managed Care Arrangements (Line (11.6))

The managed care credit is based on the percentage of paid claims that fit into each of these categories. Total claims payments are allocated among these managed care categories to determine the weighted average discount, which is then used to reduce the Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental RBC.

In some instances, claims payments may fit into more than one category. If that occurs, the claims payments are allocated among these managed care categories to determine the weighted average discount. Each managed care category is a “bucket” and each “bucket” is assigned a discount factor. The total claims payments reported in the managed care worksheet should equal the total year’s paid claims. Category 2a, Category 2b and Category 3c are not allowed to include non-regulated intermediaries who are affiliated with the reporting company in order to ensure that true risk transfer is accomplished.

The managed care credit is the result of a calculation that takes into account the variability of claims payments and the predictability of future claims payments. The managed care credit is then used to reduce the RBC requirement for experience fluctuations. The managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost.

The reduction in uncertainty is determined by the variability of claims payments and the predictability of future claims payments. The managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claims payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

For Stand-Alone Medicare Part D coverage, the reduction in uncertainty comes from two federal supports: the reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Line (11) will have the following three components:

- Category 0 - Arrangements not Included in Other Categories (Line (11.1))
- Category 1 - Contractual Fee Payments (Line (11.2))
- Category 2 - Bonus and/or Incentives / Withhold Arrangements (Line (11.3))
- Category 3 - Capitation (Line (11.4))
- Category 4 - Non-contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements (Line (11.5))
- Category 5 - Other Managed Care Arrangements (Line (11.6))

The managed care credit is based on the percentage of paid claims that fit into each of these categories. Total claims payments are allocated among these managed care categories to determine the weighted average discount, which is then used to reduce the Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental RBC.

In some instances, claims payments may fit into more than one category. If that occurs, the claims payments are allocated among these managed care categories to determine the weighted average discount. Each managed care category is a “bucket” and each “bucket” is assigned a discount factor. The total claims payments reported in the managed care worksheet should equal the total year’s paid claims. Category 2a, Category 2b and Category 3c are not allowed to include non-regulated intermediaries who are affiliated with the reporting company in order to ensure that true risk transfer is accomplished.
Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withholds later released to the provider or retroactive payments made solely because of a correction to the number of members within the capitated agreement).

Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).

Claim payments not included in other categories.

**Line (2)**

Category 1 - Payments Made According to Contractual Arrangements. There is a 15 percent managed care credit for payments included in this category:

- Hospital per diems, diagnostic related groups (DRGs) or other hospital case rates.
- Non-adjustable professional case and global rates.
- Provider fee schedules.
- Relative value scale (RVS) where the payment base and RV factor are fixed by contract for more than one year.

**Line (3)**

Category 2a - Payments Made Subject to Withholds or Bonuses/Incentives with No Other Managed Care Arrangements. This category may include business that would have otherwise fit into Category 0. That is, there may be a bonus/incentive/withhold arrangement with a provider who is reimbursed based on a UCR schedule (Category 0).

The maximum Category 2a managed care credit is 25 percent. The credit is based upon a calculation that determines the ratio of withholds returned and bonuses and/or incentives paid to providers during the prior year to total withholds and bonuses and/or incentives available to the providers during that year. That ratio is then multiplied by the average provider withhold ratio for the prior year to determine the current year’s Category 2a managed care credit factor. Bonus and/or incentive payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to the result of the following calculation:

**EXAMPLE - 1998 Reporting Year**

| 1997 withheld / bonus payments | $750,000 |
| 1997 withheld / bonuses available | $1,000,000 |
| A. MCC Factor Multiplier | 75% - Eligible for credit |
| 1997 withheld / bonuses available | $1,000,000 |
| 1997 claims subject to withhold - gross† | $5,000,000 |
| B. Average Withhold Rate | 20% |
| Category 2 Managed Care Credit Factor (A x B) | 15% |

The resulting factor is multiplied by claims payments subject to withhold - net‡ in the current year.

† These are amounts due before deducting withhold or paying bonuses and/or incentives.
‡ These are actual payments made after deducting withhold or paying bonuses and/or incentives.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives, but otherwise had no managed care arrangements.

**Line (4)**

Category 2b - Payments Made Subject to Withholds or Bonuses/Incentives That Are Otherwise Managed Care Category 1. Category 2b may include business that would have otherwise fit into Category 1. That is, there may be a bonus/incentive/withhold arrangement with a provider who is reimbursed based on a provider fee schedule.
The Category 2 discount for claims payments that would otherwise qualify for Category 1 is the greater of the Category 1 factor or the calculated Category 2 factor.

The maximum Category 2b managed care credit is 25 percent. The minimum Category 2b managed care credit is 15 percent (Category 1 credit factor). The credit calculation is the same as found in the previous example for Category 2a.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses AND where the payments were made according to one of the contractual arrangements listed for Category 1.

Line (5)
Category 3a - Capitated Payments Directly to Providers. There is a managed care credit of 60 percent for claims payments in this category, which includes:

* All capitation or percent of premium payments made directly to licensed providers.

Enter the amount of claims payments paid DIRECTLY to licensed providers on a capitated basis.

Line (6)
Category 3b - Capitated Payments to Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

* All capitation or percent of premium payments to regulated intermediaries that in turn pay licensed providers.

Enter the amount of medical expense capitations paid to regulated intermediaries (see Appendix 1 for definition). In those cases where the capitated regulated intermediary employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

Line (7)
Category 3c - Capitated Payments to Non-Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

* All capitated or percent of premium payments to non-affiliated intermediaries that in turn pay licensed providers. (Subject to a 5 percent limitation on payments to providers or other corporations that have no contractual relationship with such intermediary. Amounts greater than the 5 percent limitation should be reported in Category 0).

Enter the amount of medical expense capitations paid to non-regulated intermediaries not affiliated with the reporting company. Do not include the amount of medical expense capitations paid to non-regulated intermediaries that are affiliated with the reporting company. These amounts should be reported in Category 0. Non-regulated intermediaries are those organizations which meet the definition of Intermediary but not regulated intermediary in Appendix 1. In cases where the capitated non-regulated intermediary (even if affiliated) employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 1 for a provider, and for an intermediary at the greater of Category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive
revisions either within or beyond a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 0 for providers and intermediaries.

**Line (8)**
Category 4 - Medical & Hospital Expense Paid as Salary to Providers. There is a managed care credit of 75 percent for claims payments in this category. Once claims payments under this managed care category are totaled, any fee for service revenue from uninsured plans (i.e., ASO or ASC) that was included on Line (7) in the underwriting risk section should be deducted before applying the managed care credit factor.

- Non-contingent salaries to persons directly providing care.
- The portion of payments to affiliated entities which is passed on as non-contingent salaries to persons directly providing care where the entity has a contract only with the company.
- All facilities related medical expenses and other non-provider medical costs generated within health facility that is owned and operated by the insurer.
- Aggregate cost payments.

Salaries paid to doctors and nurses whose sole corporate purpose is utilization review are also included in this category if such payments are classified as “medical expense” payments (paid claims) rather than administrative expenses. The Aggregate Cost method of reimbursement means where a health plan has a reimbursement plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other users of services; and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, that put their respective capital and surplus at risk in guaranteeing each other.

**Line (10.1)**
Category 0 for Stand-Alone Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

**Line (10.2)**
Category 1 for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

**Line (10.3)**
Category 2a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

**Line (10.4)**
Category 3a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

**Line (10.6)**
Total Paid Claims – The total of Column (1) paid claims should equal the total claims paid for the year as reported in Schedule H, Part 5, Columns 1 and 2, Line D16 of the annual statement.

**Line (11)**
Weighted Average Managed Care Discount – This amount is calculated by dividing the total weighted claims (Line (9) Column (2)) by the total claim payments (Line (9) Column (1)).
Weighted Average Managed Care Risk Adjustment Factor - This is the credit factor that is carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount (Line (11)).

**Lines (13) through (19)**

Lines (13) through (19) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses/incentives. This table requires data from the PRIOR YEAR to compute the current year’s discount factor.

**Line (13)**
Enter the prior year’s actual withhold and bonus/incentive payments.

**Line (14)**
Enter the prior year’s withholds and bonuses/incentives that were available for payment in the prior year.

**Line (15)**
Divides Line (13) by Line (14) to determine the portion of withholds and bonuses/incentives that were actually returned in the prior year.

**Line (16)**
Equal to Line (14) and is automatically pulled forward.

**Line (17)**
Claims payments that were subject to withholds and bonuses/incentives in the prior year. Equal to Line (3) + Line (4) of Underwriting Risk–Managed Care Credit FOR THE PRIOR YEAR.

**Line (18)**
Divides Line (16) by Line (17) to determine the average withhold rate for the prior year.

**Line (19)**
Multiplies Line (15) by Line (18) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the insurer’s withhold/bonus/incentive program in the prior year.
Incentives, Withhold and Bonus Amounts – Are amounts to be paid to providers by the Health entity as an incentive to achieve goals such as effective management of care. An incentive arrangement may involve paying an agreed-on amount for each claim, e.g., provider agrees practice in an underserved area. While a bonus arrangement may be paid at the end of the contract period after specific goals have been met. Withhold arrangements can involve a set amount to be withheld from each claim, and then paying a portion (which could be none or all) of the withheld amount at the end of the contract period.
1. Discussed the Academy’s Report on Investment Income in Underwriting Risk

Mr. Drutz said the American Academy of Actuaries (Academy) report that was exposed in December 2020 discussed the incorporation of investment income into the underwriting risk component and that additional information was requested regarding the proposed adjustment for investment income. Derek Skoog (Academy) summarized the Academy’s response (Attachment Two-B1) and said that the investment income adjustment to the underwriting factors was similar to how it is contemplated in the property/casualty (P/C) formula. He said that the Academy analyzed the comprehensive medical factors that are currently in the underwriting risk component of the health formula and assumed there was not an investment income adjustment included in the current factors. The Academy developed a set of underlying factors that would correspond to the P/C formula and then developed an investment income adjustment based on investment income that is earned on premium collected less claims paid. This considers the development and payment pattern of claims for a typical major medical policy. Then using that investment income assumption, the Academy applied that to the risk factors to develop an alternative set of experience volatility risk factors within each of the tiered factors. Mr. Skoog said that the follow-up letter laid out more detail for the arithmetic for how the investment income adjustment factor gets applied within the P/C construct and shows how the output or the resulting risk factors would result from that approach.

Mr. Chou asked if the Academy was able to look at the P/C on page PR017 for the adjustment of investment income as a factor by line for consistency between the formulas. Mr. Skoog said that served as a basis for the Academy’s analysis and said that exact approach was taken. However, rather than expanding the reporting structure in H2 of the health formula for experience volatility risk, the Academy was able to get a similar result by using industry factors. He said that the Academy opted for a simpler and higher-level approach in which the same logic was used. Mr. Chou asked if the 87.5% confidence level was used. Mr. Skoog said no. He said the original request was to consider investment income without adjusting other components of the formula. He said that if the 9% risk factor within the health risk-based capital (RBC) formula were decomposed into the P/C construct, it would basically imply an administrative expense ratio of about 9%. He said there was no investment income adjustment within the current construct, and that would imply a safety or confidence level of about a 100% loss ratio. Mr. Skoog said this would be the corresponding loss ratio in the P/C formula if the same construct was used. He said the Academy did not change those assumptions as this would have led to a more significant study of loss ratios and safety levels that would require more significant changes to the H2 component. He said that the Academy simply applied an investment income adjustment to the factors as they are currently constructed using the P/C construct.

Mr. Drutz said the letter indicated that a 0.5% return would have about a 0.07 percentage point decrease in the 9% factor for comprehensive medical. He asked if this same percentage decrease could be applied to the other tiers and lines of business on page XR012. Mr. Skoog said a similar approach could be applied to the other lines of business by looking at particular claim’s payment patterns for those lines to the extent that they may differ from comprehensive major medical. For example, Medicare Supplement paid claims are substantially slower than comprehensive major medical, so it may merit a different adjustment. However, in terms of magnitude, the adjustments would be very similar to that of the comprehensive major medical.

Jim Braue (UnitedHealth Group—UHG) summarized the UHG’s comment letter (Attachment Two-B2). He said that UHG supports making an adjustment for investment income in the formula. He said that the Academy letter noted that the amount of the adjustment is highly sensitive to the rate of investment return that is assumed, and it was also noted that statutory financial results would suggest a rate of 2% to 3%, but an amount lower may be justified by the short-term nature of the liabilities. He said that UHG believes that something consistent with a slightly longer maturity such as two to three years is more appropriate. Mr. Braue said since there is a charge applied for the risk of the bond, there should be some recognition for the income and revenue produced by those bonds. Therefore, it seems appropriate to have the revenue assumption sync up with risk assumption for the bond factors. He said the run-out period of the liabilities are not reflected in the underwriting risk factors. If it were, it would be a reserve risk and not an underwriting risk, and the risk being looked at here is the risk for future incurred claims.
being higher than future payments. He asked if current interest rates or longer-term averages should be used, as this ties into the frequency of updating the factors. If current rates are used, it implies that every time the current rate changes appreciably, the factors would need to be adjusted. If the factors were to be updated less frequently, a longer-term average rate would be more appropriate. Mr. Braue said that it is probably not appropriate to apply the adjustment to the factors for long-term disability and long-term care insurance (LTC) due to the nature of those coverages and because there is a risk charge applied to the claim reserves. However, an adjustment could be considered for those shorter-tailed coverages that behave like comprehensive medical and where the risk charges are determined in a similar fashion. He said where there are tiered factors, both tiers should be adjusted.

Mr. Drutz said there are several decision points that the Working Group will need to address prior to implementation of a factor adjustment: 1) whether the issue of bond default risk and investment revenue should be based on the same duration of assumptions; 2) the appropriate duration for applying the underwriting credit; and 3) the appropriate interest rate of return to be used in adjusting the underwriting factor.

Lou Felice (NAIC) said that from a health perspective and based on the Academy’s review, the duration of the asset holding is longer, which seems to be an appropriate measure in determining default risk because the length of time that the bond is held is related to whether there is a potential for default over that time. However, the crediting of investment income could use a one-year underwriting cycle due to the short duration of claims. He said that a one-year underwriting cycle could be a little longer as the run out is longer. However, given the short run out, given that premium changes are usually limited to once a year, and given that product design and selection changes once a year, a one-year time period could be used as an under-investment risk duration. He said that for health specifically, bond default risk and investment return risk are not as well connected as they are for P/C, so different durations could be considered for default risk on bonds versus underwriting risk benefit from investment income. Mr. Felice said that the frequency of review is tied to the rate selected, so if a smaller return percentage is used, then the factors would need to be reviewed more frequently and a larger return percentage could be reviewed less frequently. He said if a risk-free or pegged rate were used, the factors would need to be reviewed very frequently. However, if portfolio rates were used, they would need to be reviewed less frequently. There are two items to consider with portfolio rates: 1) whether perverse incentives are created to get more credit by investing in risky assets to raise their portfolio rates of return; and 2) changes to the bond factors or asset risk factors may not have as robust of changes to the underwriting risk factors in the formula. Therefore, a small change to the underwriting risk factors may have more of an impact on RBC after covariance than a larger change to a bond factor or asset factor.

Mr. Drutz said that if there is no structural change, the factor updates could be relatively simple. He said there are a couple of methods that could be considered for updating: 1) if a five-year duration were used, the adjustment could be tied to a five-year Treasury bond or some other bond that was published, which could then be used to adjust the factors on an annual basis; or 2) it could be tied to the average investment income of companies. Mr. Drutz suggested that the Working Group run an analysis on the 2019 health RBC data to determine the impact of incorporating the investment income adjustment in the underwriting risk factors and the impact that it would have on RBC ratios. Mr. Muldoon agreed that an impact analysis was a good idea to see what kind of impacts these changes would have.

Mr. Muldoon also asked what lines of business on page XR012 would be considered under the adjusted factors. Crystal Brown (NAIC) asked if the Academy would be able to provide the Working Group with adjusted factors for each line of business in which the investment income would be incorporated into. Mr. Skoog said that the Academy could provide updated factors by line of business, but it would be easier to isolate the lines of business that the adjustment should be applied to because premium collection relative to claims payout patterns would need to be considered.

Mr. Drutz said that the Working Group would like to come to a conclusion on both the bond factors and investment income adjustment projects at the same time and implement for year-end 2021 if possible. Therefore, the Working Group will need to look at the materiality and impact of the investment income adjustment and determine which lines of business the adjustment would apply to. Ms. Brown asked how long it would take the Academy to provide factors for the additional lines of business. Mr. Skoog said that some lines of business will be more challenging than others to get a good view of claim payment patterns. He said that comprehensive medical, Medicare Supplement, dental and vision, and stand-alone Medicare Part D coverage are the most straightforward lines of business, while other health and other non-health may be more challenging because of the number of products that fall under these categories. He said page XR012 would be the most straightforward page and said that the Academy could provide updated factors to the Working Group within a few weeks. Mr. Felice asked if it was necessary to incorporate the investment income adjustment across all the lines of business this year or could the most straightforward lines of business include the adjustment this year and then continue working on the other lines of business. Mr. Felice also asked for clarification on including the adjustment across the tiers and what the Academy thinks about this. Mr. Skoog said that it was
not originally included but that it should apply to all tiers. He said the Academy could provide this. Mr. Braue said that the majority of business is going to be included in Columns 1–4 on page XR012. He suggested that the Academy work on providing adjusted factors for just those four lines of business for year-end 2021 and then over the longer term look at the other lines of business that are more difficult to analyze to determine if any of them are material enough to make any difference. Mr. Skoog said that the Columns 1–4 lines of business are the most straightforward and that the Academy could work on those for this year.

The Working Group agreed and requested that the Academy look at the lines of business in Columns 1–4 on page XR012 and provide an updated analysis like the comprehensive medical and incorporate the tier breakdowns.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.
January 11, 2021

Steve Drutz  
Chair, Health Risk-Based Capital (E) Working Group  
National Association of Insurance Commissioners (NAIC)  

Re: Request for Analysis to Incorporate Investment Income into the Underwriting Risk Component of the Health Risk-Based Capital Formula

Dear Mr. Drutz:

On behalf of the American Academy of Actuaries (Academy)¹ Health Solvency Subcommittee, I am pleased to provide this response letter to the NAIC Health Risk-Based Capital (HRBC) Working Group. This letter is in response to the request from the HRBC Working Group to provide additional detail regarding the potential investment income adjustment factor for Health H2 Experience Fluctuation Risk.

**Incorporation of Investment Income into H2 Risk Factors**

As described in our letter dated December 15, 2020, the property and casualty (P&C) framework with respect to the Investment Income Adjustment (IIA) within the P&C Net Written Premium Risk (akin to the Health H2 Experience Fluctuation Risk), the base RBC charge amounts to:

\[
\text{Premium} \times (\text{IIA} \times \text{Risk\_Factor} + \text{Expense\_Ratio} - 1)
\]

The IIA*Risk\_Factor expression is the discounted loss ratio at the target safety margin (87.5th percentile for P&C). Then, the IIA*Risk\_Factor + Expense\_Ratio -1 is the discounted operating loss at the target safety margin.

For Comprehensive Major Medical, if a 9% expense ratio (based on high-level industry benchmarking of health plan administrative expenses, excluding loss adjustment expense) is assumed and no IIA (i.e., an IIA of 1.0), then the underlying Risk Factor is 100%. This is essentially the loss plus loss adjustment expense ratio at the target safety margin implied by the Health RBC formula.

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¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
The table below summarizes a range of risk factors if an investment income adjustment was applied, assuming a consistent 100% loss and loss adjustment expense ratio and a 9% expense ratio.

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<th>Investment Income Adj. (b)</th>
<th>Loss Ratio at safety margin (c)</th>
<th>Expense Ratio (d)</th>
<th>Discounted Risk Factor (b)*(c)+(d)-1</th>
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If you have any questions or would like to discuss further, please contact Matthew Williams, the Academy’s senior health policy analyst, at williams@actuary.org.

Sincerely,
Derek Skoog, MAAA, FSA
Chairperson
Health Solvency Subcommittee
American Academy of Actuaries

Cc: Crystal Brown, Senior Insurance Reporting Analyst
January 13, 2021

Mr. Steven Drutz, Chair  
Health Risk-Based Capital (E) Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

Via electronic mail to Crystal Brown.

Re: American Academy of Actuaries letters regarding an investment income adjustment to Health RBC underwriting risk factors.

Dear Mr. Drutz:

I am writing on behalf of UnitedHealth Group, to supplement our January 6, 2021 letter to you regarding the incorporation of investment income into the Risk-Based Capital (RBC) charges for health underwriting risk. As we noted in that letter, the American Academy of Actuaries was expected to provide additional details of the calculations shown in their December 15, 2020 letter, and we stated that we might have further comments when those details became available. The Academy submitted that additional information in a letter dated January 11, 2021. Our comments in response to that letter follow.

The Academy has explained that they have calculated “discounted risk factors” using the following formula:

\[
\text{Discounted risk factor} = \text{IIA} \times (\text{Loss ratio at safety margin}) + (\text{Expense ratio}) - 1
\]

where “IIA” is an Investment Income Adjustment. As we understand it, the IIA represents a discount factor at the indicated rate of investment return, discounted over a period of slightly more than 1.5 months. (Although the exact discounting period is not stated in either of the Academy’s letters, from the calculated values it appears that the period is approximately 0.1339 years, or 1.607 months.)

The underwriting risk factors were originally based on modeling over a multiyear period, and from that standpoint it seems that the discounting should occur continuously over that period (or, more approximately, back from the midpoint of the modeling period). However, in that case, the premiums would also have to be discounted, which would result in the constant term in the
above equation being less than 1. The IAA, then, can be interpreted as an approximation of the difference between the impact of discounting on the loss ratio and the impact of discounting on the premium, as the 1.6-month period approximates the difference in timing between the receipt of the premium and the payment of the corresponding claims. Considered in that light, the adjustment seems reasonable.

We will note that, potentially, a similar adjustment should be made to the expense ratio. However, because the expense ratio used by the Academy is so much lower than the loss ratio that they used (9% vs. 100%), there would be much less impact on the final result. Therefore, the lack of an adjustment on the expense ratio could be viewed as providing a small degree of conservatism.

Given the interpretation of the IIA that we’ve presented above, it is important to note that the 1.6-month discounting period has no relevance to the question of what rate of investment return should be assumed. The 1.6-month discounting period really should be thought of as the difference between two amounts discounted over a longer period. As we explained in our January 6 letter, the assumed rate of investment return should be consistent with investments held for a period of two to three years. The information in this latest letter from the Academy does not alter that position in any way.

We would be happy to discuss these comments with you and the Working Group.

James R. Braue  
Director, Actuarial Services  
UnitedHealth Group  
cc: Crystal Brown, NAIC  
Randi Reichel, UnitedHealth Group
January 6, 2021

Mr. Steven Drutz, Chair
Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO  64106-2197

Via electronic mail to Crystal Brown.

Re: American Academy of Actuaries letter regarding an investment income adjustment to Health RBC underwriting risk factors.

Dear Mr. Drutz:

I am writing on behalf of UnitedHealth Group in regard to the December 15, 2020 letter to you from the American Academy of Actuaries (the “Academy”), exposed for comment on December 18, 2020. The letter presented the Academy’s analysis of incorporating investment income into the Risk-Based Capital (RBC) charges for health underwriting risk.

We greatly appreciate your Working Group’s willingness to address this subject. We hope that our comments on the Academy’s letter will assist the Working Group in its further consideration of the matter. We have comments on several distinct aspects of the letter, as shown under separate headings below.

During the Working Group’s December 18, 2020 conference call, we requested additional details of the calculations shown in the Academy’s letter. We understand that the Academy is preparing to provide those details. As of this writing, we have not yet seen that additional material, and our comments below should be considered in that context. When that material becomes available, we may have additional comments regarding it.

Our support for an adjustment.

It is definitely appropriate for an adjustment to be made. We understand the Academy’s remark that, “making this change in the RBC formula may be an exercise in false precision because the baseline factors are not well understood.” However, that is not a reason to forgo the adjustment. The current underwriting risk factors are what they are, whether they are well understood or not; they are the baseline we all must work from. The adjustment for investment income should
therefore not be thought of as one element of the development of those factors, which might be offset by other elements that are currently unidentified. Instead, the adjustment should be viewed simply as the introduction of an investment income component into the formula, by means of adjusting the existing underwriting risk factors. Conceptually, the adjustment could be a stand-alone negative component of underwriting risk; the fact that it is instead being added to the existing underwriting risk factors does not somehow invalidate its appropriateness.

Accordingly, we strongly recommend that the Working Group adopt an adjustment to the underwriting risk factors as discussed in the Academy’s letter. As we noted at the Working Group’s July 30, 2020 virtual meeting, and reiterated in our August 31 comment letter, if for some reason the Working Group does not consider it feasible to implement this adjustment as part of the underwriting risk portion of the RBC formula, then it will be necessary to return to the subject of incorporating investment income into the bond risk factors.

Rate of investment return.

The Academy’s letter notes that the amount of the adjustment is highly sensitive to the rate of investment return that is assumed in the calculation. The Academy states that statutory financial results would suggest a rate of 2-3%, but also suggests that the short-term nature of the liabilities (about 1.5 months on average, the letter indicates) might justify a much lower rate.

The run-out period of a single incurral date’s claims should not be the determinative consideration, for several reasons. First of all, while the Working Group’s deliberations on the bond risk factors are not complete, most recently the Working Group has been contemplating using a 3-year average maturity assumption for that purpose. As we have noted previously, if the risk associated with health entities’ bond holdings is to be reflected in the RBC formula, it is important that the corresponding returns likewise be reflected. If (as we had originally recommended) the investment return were being incorporated into the bond risk factors themselves, that linkage would be readily apparent. Merely because the investment returns are instead being incorporated into the underwriting risk factors, that linkage is not somehow broken.

Also, we suggest that the run-out period of a single incurral date’s claims is not really relevant from an investment standpoint. As a going concern, a health entity does not repeatedly run its assets down to zero as claims are paid; there is a continual inflow of cash from premiums and other revenues, and investments are held for a longer term (approximating the 3-year average maturity referred to above). Even in a run-out situation, it is unlikely that all payments would run out as quickly as the 1.5-month average cited by the Academy would suggest. We will point out that the Academy, in its August 2018 update on bond risk factors, said, “To estimate the liability runoff duration, we review (a) the duration of unpaid claim liabilities and (b) the duration of claim liabilities and related premium from an additional year of policies.” As a result of that review, the Academy selected a 2-year horizon for the bond risk modeling.

In summary, the rate of investment return should be consistent with the time horizon used for the bond risk modeling, whatever that is eventually determined to be. In light of the most recent discussions regarding the bond factors, we would expect that to be either 2 or 3 years.
Another consideration is whether the assumed rate of return should be based on current interest rate levels, or on longer-term averages. This consideration is tied in with the question of how frequently the investment income adjustment should be updated, which we address below.

**Scope of application.**

During the December 18 call, you raised the question of which Health RBC underwriting risk factors should be subject to the investment income adjustment. Because the pricing and reserving characteristics of long-term disability income and long-term care coverages are so different from those of the majority of the business subject to the Health formula, it makes sense to us that those categories would be excluded. For the other, shorter-tailed lines of business subject to the formula, it seems reasonable to apply the investment income adjustment. Also, where a particular product’s underwriting risk factor is tiered by premium volume, the adjustment should be applied to all tiers.

**Frequency of updates.**

Also during the December 18 call, NAIC staff raised the question of how frequently the investment income adjustment should be updated. As we noted above, we believe that this question is closely related to the question of whether the adjustment should be based on current interest rates or on a longer-term average. If the adjustment is based on current rates, it should be updated whenever market interest rates change significantly. If less frequent updates are desired by the Working Group, then it would be appropriate to use a longer-term average of rates to determine the adjustment.

* * * * *

We appreciate your consideration of these comments. We would be happy to discuss this matter further with the Working Group.

James R. Braue  
Director, Actuarial Services  
UnitedHealth Group

cc: Crystal Brown, NAIC  
Randi Reichel, UnitedHealth Group
Draft: 1/29/21

Health Risk-Based Capital (E) Working Group
Virtual Meeting
December 18, 2020

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Dec. 18, 2020. The following Working Group members participated: Steve Drutz, Chair (WA); Steve Ostlund (AL); Eric Unger (CO); Wanchin Chou and Andrew Greenhalgh (CT); Kyle Collins (FL); Brenda Johnson and Chut Tee (KS); Rhonda Ahrens and Michael Muldoon (NE); Kelsey Barlow (NV); Tom Dudek (NY); Kimberly Rankin (PA); and Aaron Hodges and Mike Boerner (TX).

1. Referred the Health Care Receivable Proposal to the Blanks (E) Working Group

Mr. Drutz said the health care receivable proposal provides additional clarification on the annual statement instructions as a result of feedback in the drafting of the health care receivable guidance. The recommended changes include: 1) adding a reference to “Other Health Care Receivables” in Line 24 of the Assets page; 2) adding “Health Care” to the “Other Receivables” line on Exhibit 3 for consistency across the schedules and risk-based capital (RBC); and 3) modifying the headers of Exhibit 3A to provide additional clarification. No comments were received during the 30-day public comment period.

Mr. Boerner made a motion, seconded by Mr. Dudek, to refer the Health Care Receivable Proposal to the Blanks (E) Working Group for consideration in 2021 reporting (Attachment Two-C1). The motion passed unanimously.

2. Exposed the Academy’s Report on Investment Income in Underwriting Risk

Mr. Drutz said the incorporation of investment income into the health RBC formula was brought forward by industry participants through the bond factor discussion. Including investment income within the bond factors would require several considerations; therefore, the Working Group agreed to instead look at incorporating investment income into the Underwriting Risk component. The Working Group asked the American Academy of Actuaries (Academy) to review and analyze incorporating investment income into Underwriting Risk component of the health RBC formula.

Derek Skoog (Academy) said the Academy studied the background of the underwriting risk factors, and given their age, the task was somewhat challenging. The Academy was able to refer to an old Academy report, and it found that the calibration of the factors was different than the property and casualty formula; however, it was still able to decompose the factors into a construct similar to the property and casualty formula for the purposes of the investment income adjustment. Mr. Skoog said the Academy went through that exercise with the major medical base risk charge of 9% in a range of investment income return assumptions. He said depending on the investment return, the underwriting risk factor could go from 9% to 8.6% with an investment return of 3% and then graded between the 8.6% and 9% for lower investment returns.

Mr. Skoog said one of the challenges is determining what the investment return should be due to sensitivity. He said given the low interest rate environment—something between 0–1% range—may make the most sense; but ultimately, that is a decision of the Working Group. He said the other item tested was the speed of which claims are completed because you are essentially earning investment income under this approach based on whatever residual premium you have after you have paid claims. To the extent that it takes longer to pay claims, you get more of an investment income benefit. Mr. Skoog said the Academy used a normal working claims completion rate so that the results are not overly sensitive to that as they are to the actual investment return. However, there is still some sensitivity; therefore, a range of outcomes was presented. Mr. Skoog said one of the fundamental challenges is in the underlying factors themselves because the base risk charges that are presented within the health RBC formula are a bit dated and do not necessarily tie to quantitative results as they do in the property and casualty formula, which can make any analysis somewhat challenging.

Jim Braue (UnitedHealth Group—UHG) asked if the investment return assumption was the 2–3% return on invested assets. Mr. Skoog said that was correct; it was from the statutory schedules by looking at the return on invested assets relative to invested assets on the balance sheet. Mr. Braue said one month treasury rates may not be relevant to this discussion because for the purposes of the bond factors, the Working Group is looking at a two- to three-year maturity range. He said it would seem appropriate that if the regulated legal entity is being charged for the risk of those longer investments, then it should likewise receive the benefit of those longer investments. Therefore, the return assumption should be consistent with the maturity assumption used for the bond factors to maintain consistency of the risk and return throughout the formula.
Mr. Braue asked for further clarification on how to get from Column 1 to Column 2 and then to Column 3 on the Risk Factor table within the report. He suggested that an example would be helpful to follow the development. He said there was a note in the final paragraph that making a change to the formula could be an exercise in false precision. He said there is a lot of rounding in the existing underwriting risk factors, and had this been incorporated into the original factors, that rounding may have eliminated this effect anyway; but what we have today is a 9% factor, so we should not necessarily be concerned about whether the net of the 9% and this adjustment has a reasonable degree of precision but instead think about whether the adjustments to the 9% factor are appropriate.

Mr. Skoog said the Academy could provide an update on the formulas and description used to move from Columns 1 through 3 on the Risk Factor table. Mr. Chou asked how the 87.5th percentile translated into the adjusted factor. Mr. Skoog said this is how property and casualty developed the risk factor. He said it is essentially the loss ratio at that level of confidence. He said health does not have that same level of construct, but if you were to reconstruct the health risk factor the same as property and casualty risk factors were constructed, it would imply that the risk factor was about a 100% loss ratio. However, because the factor is dated and the Academy does not have the work papers on how it was built, it would be the implied health loss ratio at that same confidence level. Mr. Chou asked if the loss ratio would be at 100% if the confidence level was at the 87.5th percentile. Mr. Skoog agreed and said if you assume that today the health formula does not have an investment income adjustment, and we assume that an expense ratio for a typical health plan is about 9%, excluding claims adjustment expenses, the implied loss ratio at that confidence level is 100%.

Mr. Ostlund said duration is considered in determining the appropriate rate. He said there are times when RBC has looked at long durations for longer duration bonds; however, in this instance, we have a claim payment on major medical claims that have a very short duration, and the Academy appropriately chose the short duration and interest rate to use. He said he agrees with the Academy’s recommendation to use a short duration rather than a longer duration.

Mr. Drutz asked if an investment return of 1% was used, would the factors be reduced by 0.13 percentage point across all tiers and lines of business. Mr. Skoog said you could essentially use the 1% as a scaler for other similar lines of business, so it would then be the 0.9854 factor. Mr. Drutz asked if there was a contemplation about applying the adjustment to only the Experience Fluctuation Risk page or whether it would be applied to other lines, such as federal employee health benefits or disability lines. Mr. Skoog said the Academy did think about this; the same logic holds across the lines within your experience fluctuation risk, and a similar scaler makes sense. However, the one thing to be mindful of is that there is some sensitivity to claim payment pattern, so a proposed scaler may not appropriate for something that does not look like comprehensive major medical when looking at the longer tailed items. Mr. Skoog said a higher investment income adjustment may need to be considered, but the Academy would need to look at the claims payments for each of those lines of business. Lou Felice (NAIC) asked if it is more likely that the factors would have to be updated more frequently if a shorter duration is used since you would need to be more conservative and adhere closer to a treasury note, whereas with a longer duration you could maybe be less conservative in anticipation of loosening over time. He also asked if the report discussed how frequently the factors would need to be adjusted. Mr. Skoog said the Academy did not consider the frequency for updating; however, in the prevailing interest rate environment, it is the most impactful reason to adjust going forward, to the extent that the interest rate environment moves past the near zero amount. He agreed that it is something worth looking at.

Hearing no objections, the Working Group agreed to expose the Academy’s report to include Investment Income in the Underwriting Risk with the additional follow-up and clarification on Columns 1 through 3 on the Risk Factor table (Attachment Two-C) for a 30-day public comment period ending Jan. 18, 2021.

3. Received a Summary of Blanks Proposals and Discussed Next Steps for the Health Test Ad Hoc Group

Mary Caswell (NAIC) provided a summary of proposals 2020-32BWG, 2020-33BWG and 2020-38BWG for the Working Group. She said proposal 2020-32BWG adds Exhibits 3 and 3A as supplements to the life blank to allow for the data capture of health care receivable information. She said the Blanks (E) Working Group also approved the posting of the health care receivable guidance that the Working Group previously referred to them, and a link to this guidance was also incorporated into the instructions of this proposal. She said proposal 2020-33BWG is a change to the references used for the health annual statement lines used within the property and casualty annual statement blank to be more consistent with the terms used in the health blank. She said the purpose of proposal 2020-38BWG is to modify the Accident and Health Policy Experience Exhibit to provide state insurance regulators additional health data and greater consistency across the blanks.
Mr. Drutz said the Health Test Ad Hoc Group had taken a pause in meeting during the development of the Blanks proposals, and he suggested that the group resume meeting to determine if they would like to provide comments on the proposals and later discuss the health test language.

4. Discussed Other Matters

Mr. Drutz said the Excessive Growth Ad Hoc Group will meet Jan. 8 and begin reviewing the data for the analysis.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.
### NAIC BLANKS (E) WORKING GROUP

**Blanks Agenda Item Submission Form**

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**FOR NAIC USE ONLY**

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| Changes to Existing Reporting [ ] |
| New Reporting Requirement [ ] |

**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

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**DISPOSITION**

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ ] Adopted Date ____________
[ ] Rejected Date ____________
[ ] Deferred Date ____________
[ ] Other (Specify) ____________

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- [ x ] ANNUAL STATEMENT
- [ x ] INSTRUCTIONS
- [ ] CROSSCHECKS
- [ ] Life, Accident & Health/Fraternal
- [ ] Property/Casualty
- [ x ] Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)

Anticipated Effective Date: ____________________________

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Clarifying language was added to Exhibit 3, Exhibit 3A and Assets page for health care receivables.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: ____________________________

Other Comments:

**This section must be completed on all forms.**

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Health 2020

ASSETS

Detail deleted

Line 24 – Health Care and Other Amounts Receivable

Include: Bills Receivable – Report any unsecured amounts due from outside sources or receivables secured by assets that do not qualify as investments.

Amounts due resulting from advances to agents or brokers – Refer to SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers for accounting guidance.

Health Care Receivables – Include pharmaceutical rebate receivables, claim overpayment receivables, loans and advances to providers, capitation arrangement receivables, and risk sharing receivables, and other health care receivables, from affiliated and non-affiliated entities. Refer to SSAP No. 84—Health Care and Government Insured Plan Receivables for accounting guidance.

Other amounts receivable that originate from the government under government insured plans, including undisputed amounts over 90 days due that qualify as accident and health contracts are admitted assets. Refer to SSAP No. 84—Health Care and Government Insured Plans Receivables and SSAP No. 50—Classifications of Insurance or Managed Care Contracts for accounting guidance.

Exclude: Pharmaceutical rebates relating to uninsured plans that represent an administrative fee and that are retained by the reporting entity and earned in excess of the amounts to be remitted to the uninsured plan. These amounts should be reported on Line 17.

Premiums receivable for government insured plans reported on Lines 15.1, 15.2 or 15.3.

EXHIBIT 3 – HEALTH CARE RECEIVABLES

Individually list the greater of any account balances greater than $10,000 or those that are 10% of gross health care receivables. Use Lines 010001 through 0699996, as needed. Report gross amounts for insured plans although these amounts may be offset against corresponding liabilities on the balance sheet. Report the aggregate of amounts not individually listed on Lines 0199998 through 0699998. The subtotal and grand total amounts should be reported on the following lines:

<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmaceutical Rebate Receivables</td>
<td>0199999</td>
</tr>
<tr>
<td>Claim Overpayment Receivables</td>
<td>0299999</td>
</tr>
<tr>
<td>Loans and Advances to Providers</td>
<td>0399999</td>
</tr>
<tr>
<td>Capitation Arrangement Receivables</td>
<td>0499999</td>
</tr>
<tr>
<td>Risk sharing Receivables</td>
<td>0599999</td>
</tr>
<tr>
<td>Other Health Care Receivables</td>
<td>0699999</td>
</tr>
<tr>
<td>Gross Health Care Receivables</td>
<td>0799999</td>
</tr>
</tbody>
</table>

Column 7 – Admitted

Total line should equal the inset amount on Line 24 of the Asset Page.
### Exhibit 3A – Analysis of Health Care Receivables Collected and Accrued

<table>
<thead>
<tr>
<th>Type of Health Care Receivable</th>
<th>Health Care Receivables Collected as of December 31 of Current Year</th>
<th>Health Care Receivables Accrued as of December 31 of Current Year</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Pharmaceutical rebate receivables</td>
<td>2. Claim overpayment receivables</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>3. Loans and advances to providers</td>
<td>4. Capitation arrangement receivables</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>5. Risk sharing receivables</td>
<td>6. Other health care receivables</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Totals</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note that the accrued amounts in Columns 3, 4 and 6 are the total health care receivables, not just the admitted portion.
December 15, 2020

Steve Drutz
Chair, Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Re: Request for Analysis to Incorporate Investment Income into the Underwriting Risk Component of the Health Risk-Based Capital Formula

Dear Mr. Drutz:

On behalf of the American Academy of Actuaries (Academy) Health Solvency Subcommittee, I am pleased to provide this response letter to the NAIC Health Risk-Based Capital (HRBC) Working Group. This letter is in response to the request from the HRBC Working Group to provide analysis to incorporate investment income into the existing underwriting risk factors within the HRBC formula.

**Incorporation of Investment Income into H2 Risk Factors**

The H2 risk factors were based on a 5% probability of ruin over a 3- to 5-year period for each line. There is a fair degree of uncertainty with respect to the development of these factors, though it is likely they were developed without consideration of offsetting investment income. To reflect investment income into these factors, we studied the property and casualty (P&C) underwriting risk factor approach, which explicitly includes investment income via an Investment Income Adjustment (IIA).

To summarize the P&C framework with respect to the IIA within the P&C Net Written Premium Risk (akin to the Health H2 Experience Fluctuation Risk), the base RBC charge amounts to:

\[ \text{Premium} \ast (\text{IIA} \ast \text{Risk}\_\text{Factor} + \text{Expense}\_\text{Ratio} - 1) \]

---

1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
The IIA*Risk_Factor expression is the discounted loss ratio at the target safety margin (87.5th percentile for P&C). Then, the IIA*Risk_Factor + Expense_Ratio -1 is the discounted operating loss at the target safety margin.

This level of clarity around the components of the risk charges does not exist for the Health risk factors, but, using certain assumptions the P&C framework can be translated into the current Health factors. For example, the base Comprehensive Major Medical risk factor is 9%; if a 9% expense ratio (based on high-level industry benchmarking of health plan administrative expenses, excluding claims adjustment expense) is assumed and no IIA (i.e., an IIA of 1.0), then the underlying Risk Factor is 100%. To estimate the IIA for a typical health product, the subcommittee used the following claims payment completion pattern and assumed that premium is collected at policy onset and investment income is earned on any premium collected less claims paid.

The results are sensitive to the assumed claim payment pattern. For example, if all claims are paid at the end of the year, a full year of investment income could be earned; if all claims were paid immediately, then no investment income could be earned. Under this illustration, the average claim is paid approximately 1.5 months after incurral—largely consistent with health product payment patterns. To the extent actual claims take longer to develop, more investment income will be earned and the Investment Income Adjustment will be larger.

The other key assumption is the investment return. Investment yields based on a high-level analysis of health plan statutory financial statements over the past several years might indicate that a 2-3% assumption would be reasonable, though that may be overstating investment income on written premiums, as approximately half of the claims are paid in about one month and the
One-month Treasury rates are near zero today. Additionally, most investment income is likely earned from surplus funds. Given this uncertainty, the subcommittee performed sensitivity testing to understand the impact returns would have on the Risk Factor, as shown below:

<table>
<thead>
<tr>
<th>Investment Return</th>
<th>Investment Income Adj.</th>
<th>Risk Charge Adj. Factor</th>
<th>Base Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0%</td>
<td>1.0000</td>
<td>1.0000</td>
<td>9.00%</td>
</tr>
<tr>
<td>0.1%</td>
<td>0.9999</td>
<td>0.9985</td>
<td>8.99%</td>
</tr>
<tr>
<td>0.5%</td>
<td>0.9993</td>
<td>0.9927</td>
<td>8.93%</td>
</tr>
<tr>
<td>1.0%</td>
<td>0.9987</td>
<td>0.9854</td>
<td>8.87%</td>
</tr>
<tr>
<td>1.5%</td>
<td>0.9980</td>
<td>0.9780</td>
<td>8.80%</td>
</tr>
<tr>
<td>2.0%</td>
<td>0.9974</td>
<td>0.9707</td>
<td>8.74%</td>
</tr>
<tr>
<td>3.0%</td>
<td>0.9960</td>
<td>0.9558</td>
<td>8.60%</td>
</tr>
</tbody>
</table>

One concern raised by the Academy’s Solvency Subcommittee is that investment income is not generally considered with respect to the underwriting of short-term health care policies. While this is true, the related claims payable reserves and corresponding assets do generate investment returns. Because reserving risk is not considered within the HRBC formula, inclusion of investment income in Experience Fluctuation Risk may be reasonable.

There is considerably more uncertainty around the development of the Health Experience Fluctuation Risk factors than P&C Net Written Premium risk factors, as it has been some time since they were materially changed. As a result, making this change in the RBC formula may be an exercise in false precision because the baseline factors are not well understood. Ultimately, the regulatory usefulness of changes to the RBC formula will depend on both a strong understanding of the starting point and the suggested change. Given the importance of Underwriting Risk factors within the HRBC formula, it may be worth revisiting their development more broadly in the future.

*****

If you have any questions or would like to discuss further, please contact Matthew Williams, the Academy’s senior health policy analyst, at williams@actuary.org.

Sincerely,

Derek Skoog, MAAA, FSA
Chairperson
Health Solvency Subcommittee
American Academy of Actuaries

Cc: Crystal Brown: Senior Insurance Reporting Analyst
February 22, 2021

Steve Drutz
Chair, Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Re: Request for Analysis to Incorporate Investment Income into the Underwriting Risk Component of the Health Risk-Based Capital Formula

Dear Mr. Drutz:

On behalf of the American Academy of Actuaries (Academy) Health Solvency Subcommittee, I am pleased to provide this response letter to the Health Risk-Based Capital (HRBC) Working Group. This letter is in response to the request from the HRBC Working Group to provide additional analysis regarding the potential investment income adjustment factor for Health H2 Experience Fluctuation Risk.

Incorporation of Investment Income into H2 Risk Factors

As per the HRBC Working Group’s request to further analyze the impact of incorporating investment income into Columns 1-4 from page XR012 – Underwriting Experience Fluctuation Risk, we have analyzed expense ratios and claims payment patterns for each type of health coverage.

The table below summarizes the assumed expense ratio for each product, the current base RBC factors, and the implied Risk Factors (i.e., loss ratios at the desired safety margins). The expense ratio assumptions were generated based on a high-level analysis of General Administrative expenses from Page 7 of the annual statement. Additionally, since stand-alone Medicare Part D coverage has effectively no claims lag, the investment income adjustment would be negligible and the RBC factors would not be impacted.

---

1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
Expense Ratio Assumption and Current RBC Factor Summary

<table>
<thead>
<tr>
<th>Typical Expense Ratio</th>
<th>Comprehensive Medical</th>
<th>Medicare Supplement</th>
<th>Dental &amp; Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - $3 Million</td>
<td>0.150</td>
<td>0.105</td>
<td>0.120</td>
</tr>
<tr>
<td>$3 - $25 Million</td>
<td>0.150</td>
<td>0.067</td>
<td>0.076</td>
</tr>
<tr>
<td>Over $25 Million</td>
<td>0.090</td>
<td>0.067</td>
<td>0.076</td>
</tr>
</tbody>
</table>

Implied Risk Factor (loss ratio)

| $0 - $3 Million | 106% | 97% | 99% |
| $3 - $25 Million | 106% | 93% | 95% |
| Over $25 Million | 100% | 93% | 95% |

Also, in order to calculate the investment income impact, the following cumulative claims payment patterns were utilized. Since Dental and Vision share a column within the RBC formula, we used a blended completion factor assuming 75% weighting for dental and 25% weighting for vision. The Comprehensive Medical (CM) completion pattern is consistent with our prior analyses.

Claim Payment Pattern Assumption

<table>
<thead>
<tr>
<th>Months of Run Out</th>
<th>CM</th>
<th>Medicare Supplement</th>
<th>Dental</th>
<th>Vision</th>
<th>D&amp;V Blended</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>50%</td>
<td>10%</td>
<td>50%</td>
<td>70%</td>
<td>55%</td>
</tr>
<tr>
<td>1</td>
<td>70%</td>
<td>75%</td>
<td>85%</td>
<td>92%</td>
<td>87%</td>
</tr>
<tr>
<td>2</td>
<td>85%</td>
<td>95%</td>
<td>90%</td>
<td>97%</td>
<td>92%</td>
</tr>
<tr>
<td>3</td>
<td>95%</td>
<td>96%</td>
<td>93%</td>
<td>99%</td>
<td>95%</td>
</tr>
<tr>
<td>4</td>
<td>97%</td>
<td>97%</td>
<td>95%</td>
<td>100%</td>
<td>96%</td>
</tr>
<tr>
<td>5</td>
<td>99%</td>
<td>98%</td>
<td>97%</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>6</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>100%</td>
<td>99%</td>
</tr>
<tr>
<td>7</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>8</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Utilizing the same approach described in our previous letters\(^2\) to the HRBC Working Group on this topic, the resulting Tiered RBC factors were calculated using a range of investment return assumptions.

---

\(^2\) [https://www.actuary.org/sites/default/files/2021-01/HEALTHSOLVENCY_Investment_Income_H2_Considerations_to_NAIC_Follow_Up_Letter.pdf](https://www.actuary.org/sites/default/files/2021-01/HEALTHSOLVENCY_Investment_Income_H2_Considerations_to_NAIC_Follow_Up_Letter.pdf); [https://www.actuary.org/sites/default/files/2020-12/HEALTHSOLVENCY_Investment_Income_H2_Considerations_Letter_to_NAIC.pdf](https://www.actuary.org/sites/default/files/2020-12/HEALTHSOLVENCY_Investment_Income_H2_Considerations_Letter_to_NAIC.pdf); [https://www.actuary.org/sites/default/files/2020-03/Bond%20Factors%20HRBC%20Horizon%20Results.pdf](https://www.actuary.org/sites/default/files/2020-03/Bond%20Factors%20HRBC%20Horizon%20Results.pdf)
Investment Income Adjusted Tiered RBC Factors

<table>
<thead>
<tr>
<th>Assumed Investment Return</th>
<th>CM</th>
<th>Medicare Supplement</th>
<th>Dental/ Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Tier (i.e., less than $3M or less than $25M)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.0%</td>
<td>15.0%</td>
<td>10.5%</td>
<td>12.0%</td>
</tr>
<tr>
<td>0.1%</td>
<td>15.0%</td>
<td>10.5%</td>
<td>12.0%</td>
</tr>
<tr>
<td>0.5%</td>
<td>14.9%</td>
<td>10.4%</td>
<td>11.9%</td>
</tr>
<tr>
<td>1.0%</td>
<td>14.8%</td>
<td>10.4%</td>
<td>11.9%</td>
</tr>
<tr>
<td>1.5%</td>
<td>14.7%</td>
<td>10.3%</td>
<td>11.8%</td>
</tr>
<tr>
<td>2.0%</td>
<td>14.7%</td>
<td>10.2%</td>
<td>11.8%</td>
</tr>
<tr>
<td>3.0%</td>
<td>14.6%</td>
<td>10.1%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Low Tier</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.0%</td>
<td>9.00%</td>
<td>6.70%</td>
<td>7.60%</td>
</tr>
<tr>
<td>0.1%</td>
<td>8.99%</td>
<td>6.69%</td>
<td>7.59%</td>
</tr>
<tr>
<td>0.5%</td>
<td>8.93%</td>
<td>6.63%</td>
<td>7.55%</td>
</tr>
<tr>
<td>1.0%</td>
<td>8.87%</td>
<td>6.56%</td>
<td>7.50%</td>
</tr>
<tr>
<td>1.5%</td>
<td>8.81%</td>
<td>6.50%</td>
<td>7.45%</td>
</tr>
<tr>
<td>2.0%</td>
<td>8.74%</td>
<td>6.43%</td>
<td>7.40%</td>
</tr>
<tr>
<td>3.0%</td>
<td>8.61%</td>
<td>6.30%</td>
<td>7.31%</td>
</tr>
</tbody>
</table>

We note that the CM RBC factor changed from 8.60% to 8.61% due to a change in the rounding detail utilized within the calculation. Otherwise, the CM column is unchanged.

*****

If you have any questions or would like to discuss further, please contact Matthew Williams, the Academy’s senior health policy analyst, at williams@actuary.org.

Sincerely,

Derek Skoog, MAAA, FSA
Chairperson
Health Solvency Subcommittee
American Academy of Actuaries

Cc: Crystal Brown: Senior Insurance Reporting Analyst
### Number of Companies by Percent Change

#### 0.5% Investment Income - Number of Companies by Percentage Change

| Change | 0-0.5% | 0.5-1% | 1.0-1.5% | 1.5-2% | 2.0-2.5% | 2.5-3% | 3.0-3.5% | 3.5-4% | 4.0-4.5% | 4.5-5% | 5.0-5.5% | 5.5-6% | 6.0-6.5% | 6.5-7% | 7.0-7.4% | 7.4-8% |
|--------|--------|--------|----------|--------|----------|--------|----------|--------|----------|--------|----------|--------|----------|--------|----------|
|        | 560    | 309    | 137      | 3      | 2        | 0      | 0        | 0      | 0        | 0      | 0        | 0      | 0        | 0      | 0        | 0      |

#### 1.0% Investment Income - Number of Companies by Percentage Change

| Change | 0-0.5% | 0.5-1% | 1.0-1.5% | 1.5-2% | 2.0-2.5% | 2.5-3% | 3.0-3.5% | 3.5-4% | 4.0-4.5% | 4.5-5% | 5.0-5.5% | 5.5-6% | 6.0-6.5% | 6.5-7% | 7.0-7.4% | 7.4-8% |
|--------|--------|--------|----------|--------|----------|--------|----------|--------|----------|--------|----------|--------|----------|--------|----------|
|        | 369    | 273    | 234      | 63     | 68       | 0      | 0        | 1      | 1        | 0      | 0        | 0      | 0        | 0      | 0        | 0      |

#### 1.5% Investment Income - Number of Companies by Percentage Change

| Change | 0-0.5% | 0.5-1% | 1.0-1.5% | 1.5-2% | 2.0-2.5% | 2.5-3% | 3.0-3.5% | 3.5-4% | 4.0-4.5% | 4.5-5% | 5.0-5.5% | 5.5-6% | 6.0-6.5% | 6.5-7% | 7.0-7.4% | 7.4-8% |
|--------|--------|--------|----------|--------|----------|--------|----------|--------|----------|--------|----------|--------|----------|--------|----------|
|        | 319    | 87     | 131      | 212    | 237      | 17     | 1        | 4      | 1        | 1      | 1        | 0      | 1        | 0      | 0        | 0      |

#### 2.0% Investment Income - Number of Companies by Percentage Change

| Change | 0-0.5% | 0.5-1% | 1.0-1.5% | 1.5-2% | 2.0-2.5% | 2.5-3% | 3.0-3.5% | 3.5-4% | 4.0-4.5% | 4.5-5% | 5.0-5.5% | 5.5-6% | 6.0-6.5% | 6.5-7% | 7.0-7.4% | 7.4-8% |
|--------|--------|--------|----------|--------|----------|--------|----------|--------|----------|--------|----------|--------|----------|--------|----------|
|        | 311    | 44     | 89       | 163    | 177      | 78     | 132      | 8      | 2        | 2      | 0        | 2      | 1        | 1      | 1        | 1      |
### Number of Companies by Point Change

#### .5% Investment Income - Number of Companies by Point Change

<table>
<thead>
<tr>
<th>Less than 0</th>
<th>No Change</th>
<th>0-10 points</th>
<th>11-20 points</th>
<th>21-30 points</th>
<th>31-40 points</th>
<th>41-50 points</th>
<th>51-60 points</th>
<th>61-70 points</th>
<th>71-80 points</th>
<th>81-90 points</th>
<th>91-100 points</th>
<th>More than 100 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>432</td>
<td>506</td>
<td>44</td>
<td>9</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

#### 1.0% Investment Income - Number of Companies by Point Change

<table>
<thead>
<tr>
<th>Less than 0</th>
<th>No Change</th>
<th>0-10 points</th>
<th>11-20 points</th>
<th>21-30 points</th>
<th>31-40 points</th>
<th>41-50 points</th>
<th>51-60 points</th>
<th>61-70 points</th>
<th>71-80 points</th>
<th>81-90 points</th>
<th>91-100 points</th>
<th>More than 100 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>270</td>
<td>587</td>
<td>108</td>
<td>15</td>
<td>7</td>
<td>8</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

#### 1.5% Investment Income - Number of Companies by Point Change

<table>
<thead>
<tr>
<th>Less than 0</th>
<th>No Change</th>
<th>0-10 points</th>
<th>11-20 points</th>
<th>21-30 points</th>
<th>31-40 points</th>
<th>41-50 points</th>
<th>51-60 points</th>
<th>61-70 points</th>
<th>71-80 points</th>
<th>81-90 points</th>
<th>91-100 points</th>
<th>More than 100 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>270</td>
<td>460</td>
<td>176</td>
<td>48</td>
<td>16</td>
<td>12</td>
<td>4</td>
<td>6</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>

#### 2.0% Investment Income - Number of Companies by Point Change

<table>
<thead>
<tr>
<th>Less than 0</th>
<th>No Change</th>
<th>0-10 points</th>
<th>11-20 points</th>
<th>21-30 points</th>
<th>31-40 points</th>
<th>41-50 points</th>
<th>51-60 points</th>
<th>61-70 points</th>
<th>71-80 points</th>
<th>81-90 points</th>
<th>91-100 points</th>
<th>More than 100 points</th>
</tr>
</thead>
<tbody>
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<td>13</td>
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<td>7</td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>14</td>
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</tbody>
</table>
**Capital Adequacy (E) Task Force**

**RBC Proposal Form**

| [ ] Catastrophe Risk (E) Subgroup | [ ] Investment RBC (E) Working Group | [ ] Longevity Risk (A/E) Subgroup |
| [ ] C3 Phase II/ AG43 (E/A) Subgroup | [ ] P/C RBC (E) Working Group |

**DATE:** 3-17-21

**CONTACT PERSON:** Crystal Brown

**TELEPHONE:** 816-783-8146

**EMAIL ADDRESS:** cbrown@naic.org

**ON BEHALF OF:** Health RBC (E) Working Group

**NAME:** Steve Drutz

**TITLE:** Chief Financial Analyst/Chair

**AFFILIATION:** WA Office of Insurance Commissioner

**ADDRESS:** PO Box 40255

Olympia, WA 98504-0255

---

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

| [x] Health RBC Blanks | [x] Property/Casualty RBC Blanks | [x] Life and Fraternal RBC Instructions |
| [x] Health RBC Instructions | [x] Property/Casualty RBC Instructions | [x] Life and Fraternal RBC Blanks |
| [ ] OTHER ____________________________ |

**DESCRIPTION OF CHANGE(S)**

Incorporate investment income into the Underwriting Risk – Experience Fluctuation Risk factors for columns 1-3. The base underwriting factors would be adjusted for Comprehensive Medical, Medicare Supplement and Dental and Vision.

**REASON OR JUSTIFICATION FOR CHANGE **

Incorporated investment income into Columns 1-3 on the Underwriting Risk – Experience Fluctuation Risk page. The American Academy of Actuaries provided recommended factors to the Working Group. The Academy found that due to no claims lag in Stand-Alone Medicare Part D coverage, the investment income adjustment would be negligible and the RBC factors would not be impacted.

The Working Group will continue to work with the Academy to look at the potential to incorporate an investment income adjustment to the factors for the other health lines of business for 2022 or later.

**Additional Staff Comments:**

These changes will also need to be incorporated into the Life and P/C formula.

---

**FOR NAIC USE ONLY**

<table>
<thead>
<tr>
<th>Agenda Item # 2021-04-CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2021</td>
</tr>
</tbody>
</table>

**DISPOSITION**

- [ ] ADOPTED
- [ ] REJECTED
- [ ] DEFERRED TO
- [ ] REFERRED TO OTHER NAIC GROUP
- [ ] EXPOSED
- [ ] OTHER (SPECIFY)
Underwriting Risk is the largest portion of the risk-based capital charge for most reporting entities. The Underwriting Risk page generates the RBC requirement for the risk of fluctuations in underwriting experience. The credit that is allowed for managed care in this page comes from the Managed Care Credit Calculation page.

Underwriting risk is present when the next dollar of unexpected claim payments comes directly out of the reporting entity’s capital and surplus. It represents the risk that the portion of premiums intended to cover medical expenses will be insufficient to pay such expense. For example, a reporting entity may charge an individual $100 in premium in exchange for a guaranty that all medical costs will be paid by that reporting entity. If the individual incurs $101 in claims costs, the reporting entity’s surplus will decline because it did not charge a sufficient premium to pick up the additional risk for that individual.

There are other arrangements where the reporting entity is not at risk for excessive claims payments, such as when an HMO agrees to serve as a third-party administrator for a self-insured employer. The self-insured employer pays for actual claim costs, so the risk of excessive claims experience is borne by the self-insured employer, not the reporting entity. The underwriting risk section of the formula, therefore, requires some adjustments to remove non-underwriting risk business (both premiums and claims) before the RBC requirement is calculated. Appendix 1 contains commonly used terms for general types of health insurance. Refer to INT 05-05: Accounting for Revenue under Medicare Part D Cover for terms specifically used with respect to Medicare Part D coverage of prescription drugs.

Claims Experience Fluctuation

The RBC requirement for claims experience fluctuation is based on the greater of the following calculations:

A. Underwriting risk revenue, times the underwriting risk claims ratio, times a set of tiered factors. The tiered factors are determined by the underwriting risk revenue volume.

or

B. An alternative risk charge that addresses the risk of catastrophic claims on any single individual. The alternative risk charge is equal to multiple of the maximum retained risk on any single individual in a claims year. The maximum retained risk (level of potential claim exposure) is capped at $750,000 per individual and $1,500,000 total for medical coverage; $25,000 per individual and $50,000 total for all other coverage except Medicare Part D coverage and $25,000 per individual and $150,000 total for Medicare Part D coverage. Additionally, for multi-line organizations (e.g., writing more than one coverage type), the alternative risk charge for each subsequent line of business is reduced by the amount of the highest cap. For example, if an organization is writing both comprehensive medical (with a cap of $1,500,000) and dental (with a cap of $50,000), then only the larger alternative risk charge is considered when calculating the RBC requirement (i.e., the alternative risk charges for each line of business are not cumulative).

For RBC reports to be filed by a health organization commencing operations in this reporting year, the health organization shall estimate the initial RBC levels using operating (revenue and expense) projections (considering managed care arrangements) for its first full year (12 months) of managed care operations. The projections, including the risk-based capital requirement, should be the same as those filed as part of a comprehensive business plan that is submitted as part of the application for licensure. The Underwriting, Credit (capitation risk only), and Business Risk sections of the first RBC report submitted shall be completed using
the health organization’s actual operating data for the period from the commencement of operations until year-end, plus projections for the number of months necessary to provide 12 months of data. The affiliate, asset and portions of the credit risk section that are based on balance sheet information shall be reported using actual data. For subsequent years’ reports, the RBC results for all of the formula components shall be calculated using actual data.

**L(1) through L(21)**

There are six lines of business used in the formula for calculating the RBC requirement for this risk: (1) Comprehensive Medical and Hospital; (2) Medicare Supplement; (3) Dental/Vision; (4) Stand-Alone Medicare Part D Coverage; and (5) Other Health; and (6) Other Non-Health. Each of these lines of business has its own column in the Underwriting Risk – Experience Fluctuation Risk table. The categories listed in the columns of this page include all risk revenue and risk revenue that is received from another reporting entity in exchange for medical services provided to its members. The descriptions of the items are described as follows:

**Column (1) - Comprehensive Medical & Hospital.** Includes policies providing for medical coverages including hospital, surgical, major medical, Medicare risk coverage (but NOT Medicare Supplement), and Medicaid risk coverage. This category DOES NOT include administrative services contracts (ASC), administrative services only (ASO) contracts, or any non-underwritten business. These programs are reported in the Business Risk section of the formula. Neither does it include Federal Employees Health Benefit Plan (FEHBP) or TRICARE, which are handled in Line 24 of this section. Medicaid Pass-Through Payments reported as premiums should also be excluded from this category and should be reported in Line 25.2 of this section. The alternative risk charge, which is twice the maximum retained risk after reinsurance on any single individual, cannot exceed $1,500,000. Prescription drug benefits included in major medical insurance plans (including Medicare Advantage plans with prescription drug coverage) should be reported in this line. These benefits should also be included in the Managed Care Credit calculation.

**Column (2) - Medicare Supplement.** This is business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement and includes Medicare Select. Medicare risk business is reported under comprehensive medical and hospital.

**Column (3) - Dental & Vision.** This is limited to policies providing for dental-only or vision-only coverage issued as a stand-alone policy or as a rider to a medical policy, which is not related to the medical policy through deductibles or out-of-pocket limits.

**Column (4) - Stand-Alone Medicare Part D Coverage.** This includes both individual coverage and group coverage of Medicare Part D coverage where the plan sponsor has risk corridor protection. See INT 05-05: Accounting for Revenue under Medicare Part D Coverage for definition of these terms. Medicare drug benefits included in major medical plans or benefits that do not meet the above criteria are not to be included in this line. Supplemental benefits within Medicare Part D (benefits in excess of the standard benefit design) are addressed separately on page XR014. Employer-based Part D coverage that is in an uninsured plan as defined in SSAP No. 47—Uninsured Plans is not to be included here.

**Column (5) – Other Health Coverages.** This includes other health coverages such as other stand-alone prescription drug benefit plans, NOT INCLUDED ABOVE that have not been specifically addressed in the other columns listed above.

**Column (6) - Other Non-Health Coverages.** This includes life and property and casualty coverages.

The following paragraphs explain the meaning of each line of the table for computing the experience fluctuation underwriting risk RBC.
**Line (1) Premium.** This is the amount of money charged by the reporting entity for the specified benefit plan. It is the earned amount of prepayments (usually on a per member per month basis) made by a covered group or individual to the reporting entity in exchange for services to be provided or offered by such organization. However, it does not include receipts under administrative services only (ASO) contracts; or administrative services contracts (ASC); or any non-underwritten business. Nor does it include federal employees health benefit programs (FEHBP) and TRICARE. Report premium net of payments for stop-loss or other reinsurance. The amounts reported in the individual columns should come directly from Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement. For Stand-Alone Medicare Part D Coverage the premium includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D payment demonstration amounts and risk corridor payment adjustments. See INT 05-05: Accounting for Revenue under Medicare Part D Coverage for definition of these terms. It does not include revenue received for reinsurance payments or low-income subsidy (cost-sharing portion), which are considered funds received for uninsured plans in accordance with Emerging Accounting Issues Working Group (EAIWG) INT. No. 05-05. Also exclude the beneficiary premium (supplemental benefit portion) for Stand-Alone Medicare Part D coverage.

**NOTE:** Where premiums are paid on a monthly basis, they are generally fully earned at the end of the month for which coverage is provided. In cases where the mode of payment is less frequent than monthly, a portion of the premium payment will be unearned at the end of any given reporting period.

**Line (2) Title XVIII Medicare.** This is the earned amount of money charged by the reporting entity (net of reinsurance) for Medicare risk business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicare subscribers. This includes the beneficiary premium and federal government’s direct subsidy for prescription drug coverage under MA-PD plans. The total of this line will tie to the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement.

**Line (3) Title XIX Medicaid.** This is the earned amount of money charged by the reporting entity for Medicaid risk business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicaid subscribers. The total of this line will tie to the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement. Stand-Alone Medicare Part D coverage of low-income enrollees is not included in this line.

**Line (4) Other Health Risk Revenue.** This is earned amounts charged by the reporting entity as a provider or intermediary for specified medical (e.g., full professional, dental, radiology, etc.) services provided to the policyholders, or members of another insurer or health entity. Unlike premiums, which are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payments, made by another insurer or health entity to the reporting entity in exchange for services to be provided or offered by such organization. Payments to providers under risk revenue arrangements are included in the RBC calculation as underwriting risk revenue and are included in the calculation of managed care credits. Exclude fee-for-service revenue received by the reporting entity from another reporting entity. This revenue is reported in the Business Risk section of the formula as non-underwritten and limited risk revenue. The amounts reported in the individual columns will come directly from Page 7, Line 4 of the annual statement.

**Line (5) Medicaid Pass-Through Payments Reported as Premiums.** Medicaid Pass-Through Payments that are included as premiums in the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 should be reported in this line.

**Line (6) Underwriting Risk Revenue.** The sum of Lines (1) through (4) minus Line (5).

**Line (7) Net Incurred Claims.** Claims incurred (paid claims + change in unpaid claims) during the reporting year (net of reinsurance) that are arranged for or provided by the reporting entity. Paid claims include capitation and all other payments to providers for services to members of the reporting entity, as well as reimbursement directly to members for covered services. Paid claims also include salaries paid to reporting entity employees that provide medical services to
members and related expenses. Do not include ASC payments or federal employees health benefit program (FEHBP) and TRICARE claims. These amounts are found on Page 7, Line 17 of the annual statement.

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in INT 05-05: Accounting for Revenue under Medicare Part D Coverage). Where there has been prepayment under the reinsurance coverage, paid claims should be offset from the cumulative deposits. Unpaid claims liabilities should reflect expected recoveries from the reinsurance coverage, for claims unpaid by the PDP or for amounts covered under the reinsurance coverage that exceed the cumulative deposits. Where there has not been any prepayment under the reinsurance coverage, unpaid claim liabilities should reflect expected amounts still due from CMS. Exclude the beneficiary incurred claims (supplemental benefit portion) for Stand-Alone Medicare Part D coverage and report the incurred claims amount (supplemental benefit portion) on Line (25.1) of page XR014.

Line (8) Medicaid Pass-Through Payments Reported as Claims. Medicaid Pass-Through Payments that are included as claims in the Analysis of Operations by Lines of Business, Page 7, Line 17 should be reported in this line.

Line (9) Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims. Line (7) minus Line (8).

Line (10) Fee-for-Service Offset. Report fee for service revenue that is directly related to medical expense payments. The fee for service line does not include revenue where there is no associated claim payment (e.g., fees from non-member patients where the provider receives no additional compensation from the reporting entity) and when such revenue was excluded from the pricing of medical benefits. The amounts reported in the individual columns should come directly from Page 7, Line 3 of the annual statement.

Line (11) Underwriting Risk Incurred Claims. Line (9) minus Line (10).

Line (12) Underwriting Risk Incurred Claims Ratio. For Columns (1) through (5), Line (11) / Line (6). If either Line (6) or Line (11) is zero or negative, Line (12) is zero.

Line (13) Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (6), Underwriting Risk Revenue. The factors for Column 1-3 have incorporated investment income. The factors for the highlighted items to the left will be updated based on either Option 1 or Option 2.

<table>
<thead>
<tr>
<th>Line</th>
<th>Comprehensive Medical &amp; Hospital</th>
<th>Medicare Supplement</th>
<th>Dental &amp; Vision</th>
<th>Stand-Alone Medicare Part D Coverage</th>
<th>Other Health</th>
<th>Other Non-Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 – $3 Million</td>
<td>0.150</td>
<td>0.105</td>
<td>0.120</td>
<td>0.251</td>
<td>0.130</td>
<td>0.130</td>
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<tr>
<td>$3 – $25 Million</td>
<td>0.150</td>
<td>0.067</td>
<td>0.076</td>
<td>0.251</td>
<td>0.130</td>
<td>0.130</td>
</tr>
<tr>
<td>Over $25 Million</td>
<td>0.090</td>
<td>0.067</td>
<td>0.076</td>
<td>0.151</td>
<td>0.130</td>
<td>0.130</td>
</tr>
</tbody>
</table>

Line (14) Base Underwriting Risk RBC. Line (6) x Line (12) x Line (13).

Line (15) Managed Care Discount. For Comprehensive Medical & Hospital, Medicare Supplement (including Medicare Select) and Dental/Vision, a managed care discount, based on the type of managed care arrangements an organization has with its providers, is included to reflect the reduction in the uncertainty about future

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claim payments attributable to the managed care arrangements. The discount factor is from Column (3), Line (17) of the Managed Care Credit Calculation page. An average factor based on the combined results of these three categories is used for all three.

For Stand-Alone Medicare Part D Coverage, a separate managed care discount (or federal program credit) is included to reflect only the reduction in uncertainty about future claims payments attributable to federal risk arrangements. The discount factor is from Column (4), Line (17) of the Managed Care Credit Calculation page.

There is no discount given for the Other Health and Other Non-Health lines of business.

Line (16) RBC After Managed Care Discount = Line (14) x Line (15).

Line (17) Maximum Per-Individual Risk After Reinsurance. This is the maximum after-reinsurance loss for any single individual. Where specific stop-loss reinsurance protection is in place, the maximum per-individual risk after reinsurance is equal to the highest attachment point on such stop-loss reinsurance, subject to the following:

- Where coverage under the stop-loss protection (plus retention) with the highest attachment point is capped at less than $750,000 per member, the maximum retained loss will be equal to such attachment point plus the difference between the coverage (plus retention) and $750,000.

- Where the stop-loss layer is subject to participation by the reporting entity, the maximum retained risk as calculated above will be increased by the reporting entity’s participation in the stop-loss layer (up to $750,000 less retention).

Examples of the calculation are presented below:

**EXAMPLE 1 (Reporting entity provides Comprehensive Care):**

<table>
<thead>
<tr>
<th>Highest Attachment Point (Retention)</th>
<th>$100,000</th>
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</thead>
<tbody>
<tr>
<td>Reinsurance Coverage</td>
<td>90% of $500,000 in excess of $100,000</td>
</tr>
<tr>
<td>Maximum reinsured coverage</td>
<td>$600,000 ($100,000 + $500,000)</td>
</tr>
</tbody>
</table>

\[
\text{Maximum Ret. Risk} = $100,000 \text{ deductible} \\
+ $150,000 \ (600,000 - 500,000) \\
+ $50,000 \ (10\% \ of \ (600,000 - 100,000) \ coverage \ layer) \\
= $300,000
\]

**EXAMPLE 2 (Reporting entity provides Comprehensive Care):**

<table>
<thead>
<tr>
<th>Highest Attachment Point (Retention)</th>
<th>$75,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reinsurance Coverage</td>
<td>90% of $1,000,000 in excess of $75,000</td>
</tr>
</tbody>
</table>
Maximum reinsured coverage $1,075,000 ($75,000 + $1,000,000)

Maximum Ret. Risk =

$ 75,000 deductible
+ 0 ($750,000 – $1,075,000)
+$ 67,500 (10% of ($750,000 – $75,000)) coverage layer)

= $142,500

Line (18) Alternate Risk Charge. This is twice the amount in Line (17) for columns (1), (2), (3) and (5) and Column (4) is six times the amount in Line (17), subject to a maximum of $1,500,000 for Column (1), $50,000 for Columns (2), (3) and (5) and $150,000 for Column (4). Column (6) is excluded from this calculation.

Line (19) Alternate Risk Adjustment. This line shows the largest value in Line (18) for the column and all columns left of the column. Column (6) is excluded from this calculation.

Line (20) Net Alternate Risk Charge. This is the amount in Line (18), less the amount in the previous column of Line (19), but not less than zero. Column (6) is excluded from this calculation.

Line (21) Net Underwriting Risk RBC. This is the maximum of Line (16) and Line (20) for each of columns (1) through (5). This is the amount in Line (14), Column (6). The amount in Column (7) is the sum of the values in Columns (1) through (6).
### UNDERWRITING RISK

#### Experience Fluctuation Risk

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Comprehensive Medical</th>
<th>Medicare Supplement</th>
<th>Dental &amp; Vision</th>
<th>Stand-Alone Medicare Part D Coverage</th>
<th>Other Health</th>
<th>Other Non-Health</th>
<th>Total</th>
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<tr>
<td>(1) † Premium</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(2) † Title XVIII-Medicare</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(3) † Title XIX-Medicaid</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>(4) † Other Health Risk Revenue</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>(5) Medicaid Pass-Through Payments Reported as Premium</td>
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<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<td>(6) Underwriting Risk Revenue = Lines (1) + (2) + (3) + (4) - (5)</td>
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<td>XXX</td>
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<td>XXX</td>
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<tr>
<td>(7) † Net Incurred Claims</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(8) Medicaid Pass-Through Payments Reported as Claims</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(9) Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims = Lines (7) - (8)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(10) † Fee-For-Service Offset</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(11) Underwriting Risk Incurred Claims = Lines (9) - (10)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(12) Underwriting Risk Claims Ratio = For Column (1) through (5), Line (11)/(6)</td>
<td>0.130</td>
<td>0.130</td>
<td>0.130</td>
<td>0.130</td>
<td>0.130</td>
<td>0.130</td>
<td>0.130</td>
</tr>
<tr>
<td>(13) Underwriting Risk Factor*</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
</tr>
<tr>
<td>(14) Base Underwriting Risk RBC = Lines (6) x (12) x (13)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(15) Managed Care Discount Factor</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(16) RBC After Managed Care Discount = Lines (14) x (15)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(17) Maximum Per-Individual Risk After Reinsurance</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(18) Alternate Risk Charge **</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>(19) Alternate Risk Adjustment</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(20) Net Alternate Risk Charge***</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(21) Net Underwriting Risk RBC (MAX{Line (16), Line (20)}) For Columns (1) through (5), Column (6), Line (14)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>

#### TIERED RBC FACTORS*

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Comprehensive Medical</th>
<th>Medicare Supplement</th>
<th>Dental &amp; Vision</th>
<th>Stand-Alone Medicare Part D Coverage</th>
<th>Other Health</th>
<th>Other Non-Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - $3 Million</td>
<td>0.1490</td>
<td>0.0663</td>
<td>0.0755</td>
<td>0.251</td>
<td>0.130</td>
<td>0.130</td>
</tr>
<tr>
<td>$3 - $25 Million</td>
<td>0.1490</td>
<td>0.0663</td>
<td>0.0755</td>
<td>0.251</td>
<td>0.130</td>
<td>0.130</td>
</tr>
<tr>
<td>Over $25 Million</td>
<td>0.0893</td>
<td>0.0663</td>
<td>0.0755</td>
<td>0.151</td>
<td>0.130</td>
<td>0.130</td>
</tr>
</tbody>
</table>

#### ALTERNATE RISK CHARGE**

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Comprehensive Medical</th>
<th>Medicare Supplement</th>
<th>Dental &amp; Vision</th>
<th>Stand-Alone Medicare Part D Coverage</th>
<th>Other Health</th>
<th>Other Non-Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>LESSER OF:</td>
<td>$1,500,000 or 2 x Maximum Individual Risk</td>
<td>$50,000 or 2 x Maximum Individual Risk</td>
<td>$150,000 or 6 x Maximum Individual Risk</td>
<td>$50,000 or 2 x Maximum Individual Risk</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

---

* Denotes items that must be manually entered on filing software.
† The Annual Statement Sources are found on page XR013.
* This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental & Vision managed care discount factor.
*** Limited to the largest of the applicable alternate risk adjustments, prorated if necessary.
### UNDERWRITING RISK

#### Experience Fluctuation Risk

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>(1) Comprehensive Medical</th>
<th>(2) Medicare Supplement</th>
<th>(3) Dental &amp; Vision</th>
<th>(4) Stand-Alone Medicare Part D Coverage</th>
<th>(5) Other Health</th>
<th>(6) Other Non-Health</th>
<th>(7) Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) † Premium</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) † Title XVIII-Medicare</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(3) † Title XXI-Medicare</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(4) † Other Health Risk Revenue</td>
<td>XXX</td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(5) Medicaid Pass-Through Payments Reported as Premium</td>
<td>XXX</td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(6) Underwriting Risk Revenue</td>
<td>Lines (1) + (2) + (3) + (4) - (5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(7) † Net Incurred Claims</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8) Medicaid Pass-Through Payments Reported as Claims</td>
<td>XXX</td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(9) Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims</td>
<td>Lines (7) - (8)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(10) † Fee-For-Service Offset</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(11) Underwriting Risk Incurred Claims = Lines (9) - (10)</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
</tr>
<tr>
<td>(12) Underwriting Risk Claims Ratio = For Column (1) through (5), Line (11)/6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>(13) Underwriting Risk Factor*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(14) Base Underwriting Risk RBC = Lines (6) x (12) x (13)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.130</td>
<td></td>
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<tr>
<td>(15) Managed Care Discount Factor</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(16) RBC After Managed Care Discount = Lines (14) x (15)</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(17) Maximum Per-Individual Risk After Reinsurance</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(18) Alternate Risk Charge **</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(19) Alternate Risk Adjustment</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(20) Net Alternate Risk Charge***</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(21) Net Underwriting Risk RBC (MAX {Line (16), Line (20)}) for Columns (1) through (5), Column (6), Line (14)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### TIERED RBC FACTORS*

| $0 - $3 Million | Comprehensive Medical | 0.1480 | 0.1040 | 0.0750 | 0.251 | 0.130 | 0.130 |
| $3 - $25 Million | Medicare Supplement | 0.1480 | 0.1040 | 0.0750 | 0.251 | 0.130 | 0.130 |
| Over $25 Million | Dental & Vision | 0.0887 | 0.0656 | 0.0750 | 0.151 | 0.130 | 0.130 |

#### ALTERNATE RISK CHARGE**

** The Line (15) Alternate Risk Charge is calculated as follows:

<table>
<thead>
<tr>
<th>Lesser Of:</th>
<th>$150,000</th>
<th>$50,000</th>
<th>$50,000</th>
<th>$50,000</th>
<th>$50,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,500,000</td>
<td>$1,500,000</td>
<td>$1,500,000</td>
<td>$1,500,000</td>
<td>$1,500,000</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>2 x Maximum Individual Risk</td>
<td>2 x Maximum Individual Risk</td>
<td>2 x Maximum Individual Risk</td>
<td>2 x Maximum Individual Risk</td>
<td>2 x Maximum Individual Risk</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Denotes items that must be manually entered on filing software.

† The Annual Statement Sources are found on page XR013.

* This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental/Vision managed care discount factor.

*** Limited to the largest of the applicable alternate risk adjustments, prorated if necessary.
Life Risk-Based Capital (E) Working Group
Virtual Meeting
March 12, 2021

The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met March 12, 2021. The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Thomas Reedy (CA); Wanchin Chou (CT); Sean Collins (FL); Vincent Tsang (IL); Mike Yanacheak and Carrie Mears (IA); John Robinson (MN); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).


The Working Group met Feb. 26, 2021; Feb. 11, 2021; Jan. 21, 2021; Dec. 17, 2020; and Nov. 10, 2020. During its Feb. 26, 2021, meeting, the Working Group took the following action: 1) adopted an update to the mortgage reporting guidance; and 2) discussed the American Council of Life Insurers (ACLI) real estate proposal. During its Feb. 11, 2021, meeting, the Working Group took the following action: 1) discussed the Moody’s Analytics report on bonds; and 2) exposed the alternatives for the requested modification to the mortgage reporting guidance for a 10-day public comment period ending Feb. 22. During its Jan. 21, 2021, meeting, the Working Group took the following action: 1) exposed the ACLI’s real estate proposal for a public comment period ending March 8; and 2) agreed to forward the guaranty fund memorandum to the Capital Adequacy (E) Task Force. During its Dec. 17, 2020, meeting, the Working Group took the following action: 1) heard an update on economic scenario generators (ESGs); and 2) discussed the ACLI’s real estate proposal.

Mr. Boerner made a motion, seconded by Mr. Chou, to adopt the Working Group’s Feb. 26, 2021 (Attachment Three-A); Feb. 11, 2021 (Attachment Three-B); Jan. 21, 2021 (Attachment Three-C); Dec. 17, 2020 (Attachment Three-D); and Nov. 10, 2020 (see NAIC Proceedings – Fall 2020, Capital Adequacy (E) Task Force, Attachment Four) minutes. The motion passed unanimously.

2. **Discussed the ACLI’s Real Estate Proposal**

Mr. Barlow said there was one comment letter received on the ACLI’s real estate proposal. Jerry Holman (American Academy of Actuaries—Academy) presented the Academy’s comments and, while the Academy generally supports a different approach for calculating capital requirements for real estate as 30 years have passed since the current real estate factors were set, he discussed the Academy’s four areas of concern with the ACLI proposal as presented in its comment letter (Attachment Three-E).

Mr. Barlow said in the discussions of this proposal, there were several requests from the Working Group for more information. John Bruins (ACLI) said that as risk-based capital (RBC) is developed, there are two fundamental issues. The first is how much is at risk, which he said is typically the amount being held in the statutory balance sheet. In the case of real estate, he said this is depreciated cost, while for common stock it is market value. However, in both cases, the asset values are defined within the balance sheet, and this is what drives the amount at risk. He said the second issue is the determination of an appropriate factor for that risk, and this is where a lot of the analysis has been done. He presented each of the ACLI’s responses as detailed in its March 9 letter (Attachment Three-F). Mr. Barlow suggested it would be helpful for the April 6 discussion for the Working Group to focus, and for the ACLI to provide any possible additional information, on four main areas: 1) whether there should be different factors for different real estate types; 2) whether there should be an adjustment for the fair value given the concerns about the appropriateness and the amounts reported in the annual statement; 3) whether there should be different factors for Schedule A versus Schedule BA real estate; and 4) the proposed underlying base factors.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Feb. 26, 2021. The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Thomas Reedy (CA); Deborah Batista (CO); Wanchin Chou (CT); Sean Collins (FL); Mike Yanacheak and Carrie Mears (IA); Vincent Tsang (IL); John Robinson (MN); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. **Adopted an Update to the Mortgage Reporting Guidance**

Mr. Barlow said the proposed update to the mortgage reporting guidance was exposed for comment with two options: 1) updating the previous guidance; and 2) adding new guidance. One joint comment letter was received from the American Council of Life Insurers (ACLI) and the Mortgage Bankers Association (MBA).

Mike Monahan (ACLI) said the ACLI and the MBA support the alignment of the periods covered by the risk-based capital (RBC) and troubled debt restructuring (TDR) guidance. He said, operationally, either approach would accomplish the objective of aligning accounting and RBC guidance on TDR. He the ACLI and the MBA prefer option one, with the language from the Origination Date, Valuation Date, Property Value and 90 Days Past Due paragraph in option two that includes the accounting interpretations.

Mr. Barlow said incorporating the language from option two into the option one guidance would alleviate the need for potential updates in the future.

Mr. Boerner agreed and made a motion, seconded by Mr. Tsang, to adopt option one, with the modification to replace the language on Origination Date, Valuation Date, Property Value and 90 Days Past Due with the language from option two (Attachment Three-A1). The motion passed unanimously.

2. **Discussed the ACLI Real Estate Proposal**

John Bruins (ACLI) provided a PowerPoint presentation (Attachment Three-A2) of the ACLI’s real estate proposal (Attachment Three-A3). He said the structural changes of the proposal were presented to the Working Group during its Jan. 21 meeting and were exposed for public comment.

Mr. Bruins said that version of the proposal had actually been presented to the Investment Risk-Based Capital (E) Working Group four years ago. He said the proposal has been updated, and what is now included is new material. He noted the proposal is fundamentally the same. However, the data period now includes an additional four years since the proposal was originally drafted in 2015. As a result of a review of the modeling and the larger data period, the recommended factors were changed from 10% to 11%.

Mr. Bruins said, in discussions with both state insurance regulators and other interested parties, concerns were raised about having the same factor on Schedule BA real estate as for Schedule A real estate and the updated proposal increases that factor from 10% to 12%. He presented the recommended changes to Schedule A; the proposed adjustment for unrealized gains; updates to the RBC encumbrance factor; and the recommended approach for Schedule BA, which are detailed on pages 3–11 of the PowerPoint presentation.

With respect to Schedule A real estate, Mr. Bruins said the modeling was based on historical experience of the real estate portfolio, and the ACLI used two databases. The first was the NCREIF database, which begins in 1977. It is the most robust database that exists on real estate and has been in continuous existence from 1977. He said this was supplemented with another study and allowed for the study done in 1997 to be extended back to 1961, which provided essentially 60 years’ worth of experience in the commercial real estate marketplace. The modeling largely parallels that done for the July 2013 report on common stock to the Investment Risk-Based Capital (E) Working Group and looks at a portfolio of real estate over time given various historical data starting points.
In looking at that and using a two-year time horizon, Mr. Bruins said the factor comes to about 9.5%. However, if it is extended two years out to time, the worst it would result in is a factor of about 10.2%. He also said that the adjustment for unrealized gains and losses are integrated with the modeling of the base factor, so these items will need to be looked at together.

Considering that the proposal is changing factors that were put in place in the early 1990s, Mr. Robinson asked if it would be part of the ACLI’s recommendation to revisit these factors and, if so, what would the recommended time frame be.

Mr. Bruins said it would be up to the Working Group to make that determination, but he noted that one comment made in the bond modeling was that an economic cycle was typically 10 years and suggested that might be guidance on what timeline to consider.

Mr. Barlow said how often factors are updated is something to be considered at the Task Force level—not just for real estate but for all factors—and there is a plan to do it more periodically.

With respect to the 1.5% margin providing for still unknowns due to post-COVID and other impacts, Ms. Hemphill said in the March 2017 proposal, it was an estimated 8% with 2% for unknowns for a final 10% factor, and now it is at 9.5% base with a 1.5% for unknowns. She asked how the Working Group can know that is the right amount and how it evolved from the previous proposal.

Mr. Bruins said this is a decision that the state insurance regulators have made, and the margin was more backed into than derived. He said the ACLI looked at what a reasonable rounded factor would be and that the margin is the difference but is in response to state insurance regulator concerns.

Mr. Tsang said the 9.5% factor is at the 95th percentile and asked what percentile it would be if the 1.5% were added. Ms. Hemphill said it would be 96.8th percentile.

Mr. Tsang asked if the interest rate would have an impact. Mr. Bruins said it would raise it slightly.

Mr. Tsang asked if the 11% is a pre-tax number. Mr. Bruins said it is and that it is the same as the current 15%.

Mr. Schallhorn said the foreclosed real estate changed from 23% to 11% and asked if that was appropriate.

Mr. Bruins said the recommended change on foreclosed real estate is from the perspective that when a company acquires real estate through foreclosure, it is required to mark it down to market value. Because it is starting at market value, that puts it on the same basis of other real estate. He said the ACLI did not understand why there was an additional margin in the first place on foreclosed real estate and thinks the way that it is treated in Schedule A and tracked through is a reasonable recommendation to make them the same.

Mr. Reedy asked if Mr. Bruins knew what proportion of life companies’ assets would actually be in these real estate equity investments and if that proportion increased in recent years.

Mr. Bruins said that for the industry in total, it is about 1% to 1.5% of the total general account assets, and it has been increasing but not by a lot. He said part of the reason is that companies look at the 15% RBC charge, and that becomes a detriment to investment. He said he could get the statistics for the Working Group.

Mr. Chou said the real estate and the volatility due to the economic downturn could be different from one region to another and asked if the ACLI has this level of detail in its analysis that it could share with the Working Group. Mr. Bruins said he would see what the ACLI could provide.

With respect to the proposed adjustment for unrealized gains and losses, Mr. Tsang expressed concern with the possibility of double-counting because the RBC factors are applied to book value. Mr. Barlow suggested the ACLI look at this question further. Mr. Bruins said they would.

Birny Birnbaum (Center for Economic Justice—CEJ) said the life insurance industry, among other sectors of the U.S. insurance industry, is opposed to the international capital standard, which is based in large part on market valuations, with the argument being that using these abuses the matching of assets and liabilities, introduces volatility and creates a pro-cyclical situation. He asked how those positions align with this proposal.
Mr. Bruins said the ACLI is not recommending a change to statutory accounting that reflects the value of real estate, but is trying to define a risk profile that reflects varying circumstances of a property for real estate. Unlike bonds, there are not rating agencies, and one of the key factors that can be recognized is the relationship of the market as an indicator of the level of risk. With respect to volatility, he said when bonds get downgraded, the RBC goes up, and there is volatility, which he does not believe is any different. He said RBC is based on the risk profile that exists on the date of the financial statement and, if risks change because of future circumstances, then both the financial statements and the risk profiles will change. He said keeping everything stable at the worst possible point is not necessarily good for either industry or state insurance regulators.

Mr. Barlow said more discussion will take place during the Working Group’s March 12 meeting and subsequently as needed.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
To: All Insurers  
From: Life Risk-Based Capital (E) Working Group  
RE: Guidance for Troubled Debt Restructurings for December 31, 2020 and Interim Risk-Based Capital Filings (where required)  
Date: October 9, 2020, Revised February 11, 2021

Additional Guidance Adopted by the Life Risk-Based Capital Working Group

The Financial Condition (E) Committee delegated to the Life Risk-Based Capital (E) Working Group certain questions that arose as part of its June 12 memorandum. Under that delegation, the Working Group adopted the following guidance.

Construction Loans
For purposes of Note 4 to the Risk-Based Capital Reporting Instructions, government-mandated construction delays due to COVID-19 that occur at any time during 2020 are not “construction issues.” This guidance would apply to all mortgages and not just those mortgages where a COVID-19 modification occurred.

Origination Date, Valuation Date, Property Value, and 90 Days Past Due
For purposes of the Description/explanation of item in the Risk-Based Capital Reporting Instructions for Date of Origination (2), Property Value (20), Year of Valuation (21 and by reference Quarter of Valuation - 22), and 90 Days Past Due? (29), no changes to these values are required for any COVID-19 related modifications that are captured within INT 20-03: Troubled Debt Restructuring Due to COVID-19 or INT 20-07: Troubled Debt Restructuring of Certain Debt Instruments Due to COVID-19.

Contemporaneous Property Values
For purposes of computing the Contemporaneous Property Value (40) for any period ending in 2020, an insurer may use the average of the NCREIF Price Index as of 12/31/2019 and the 2020 NCREIF Price Index for the Price Index current value. This guidance applies to all mortgages and not just those mortgages where a COVID-19 modification occurred, and it applies for the filings for any period ending in 2020 only and not subsequent years.

Net Operating Income
For purposes of the NOI inputs at (14), (15), (16), and the computation of a Rolling Average NOI at (36), an insurer may report 2020 NOI (i.e., NOI for any 12-month fiscal period ending after June 30, 2020 but not later than June 30, 2021) as the greater of: (1) actual NOI as determined under the CREF-C IRP Standards or (2) 85% of NOI determined for the immediate preceding fiscal year’s annual report. This guidance with respect to 2020 NOI applies to the application of the 2020 NOI in risk-based capital reporting for 2021, 2022, and 2023. In cases where an insurer reports 85% of 2019 NOI as the 2020 NOI input, the insurer should retain information about actual 2020 NOI in its workpapers so that the information can be readily available to regulators.

Related Accounting Guidance & Updates
Please see the following for both related accounting guidance and updates to this guidance via Q&A.  
https://content.naic.org/cmte_e_lrbc.htm
(Please see related documents tab)

Questions
Any questions on this guidance should be directed to Dave Fleming by e-mail at dfleming@naic.org.
Real Estate Equity RBC Proposal
February 26, 2021
Focus Areas to Achieve Consensus

- Schedule A: Factor for Real Estate Equity investments
- Proposed Adjustment for Unrealized Capital Gains
- Update factor for RBC Adjustment for Real Estate Encumbrances
- Schedule BA: Proposed treatment consistent with Schedule A
Schedule A: Equity investments in real estate

Current status: C-1 factor of 15%
- Rationale: Article from 1991 proposed that real estate volatility is about 60 percent of that for common stock, suggesting a factor in the range of 18 percent. If one assumes full tax credit for losses, this converts to a factor of about 10% after tax.

Proposal: C-1 factor of 11%
- Rationale: Analyses of real estate performance data conducted or sponsored by ACLI/NAIC/Industry specialists suggest that the base C-1 RBC factor applicable to Schedule A real estate (including company occupied, investment, acquired by foreclosure and held for sale) should be set at 9.5%. Proposed factor increased to 11% to add conservatism.
Schedule A: Factor for Real Estate Equity investments

- Modeling based on historical experience indicates a factor of 9.5% for wholly owned real estate.


- Concerns raised by regulators and other interested parties indicate some margin for prudence in light of unknown COVID-19 impacts on economy.

- Proposal modified to recommend a base factor of 11%.

- This will be applied to Real Estate reported on Schedule A, including company occupied, investment real estate, and real estate acquired by foreclosure.

- This includes a 1.50% margin over modeled values at 95% confidence.
## Schedule A: Factor for Real Estate Equity investments

<table>
<thead>
<tr>
<th>Concern</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methodology for factor estimation does not adequately reflect market volatility, and more specifically the downturn surrounding Global Financial Crisis and possible effects of COVID-19</td>
<td>Addressed through additional modeling and margin added to proposed factor</td>
</tr>
<tr>
<td>Methodology uses Total Rate of Return in modeling.</td>
<td>This approach is consistent with common stock RBC analysis. As added conservatism, there is no offset for AVR contribution, although AVR is available to offset losses.</td>
</tr>
<tr>
<td>Discount interest rate</td>
<td>As added conservatism, losses are cumulative and not discounted.</td>
</tr>
<tr>
<td>Impact of Federal Income Tax</td>
<td>As added conservatism, all losses are projected on a cash basis with no impact of Federal Income Tax.</td>
</tr>
</tbody>
</table>
Adjustment for Unrealized Capital Gains/Losses

RBC measures the risk of loss of statutory capital

Factor Development: While the analysis and proposed factors are based on market value, Statutory Accounting sets value of real estate at depreciated cost.

- When statutory value is less than fair value, risk to statutory capital is much lower. e.g., if fair value is 150 and depreciated cost is 100, the property can lose 1/3 of its value with no impact on statutory capital. Fair value is a key component of the risk profile.
- Fair value of real estate assets held by life companies is reported in Schedule A for each individual property.

Proposal: Adjust the RBC factor to recognize the difference between fair value and statutory value when applying it to the statutory value

Rationale: The excess of fair value over the statutory value is a cushion against loss of statutory capital that is not currently recognized for risk-based capital purposes. Over time, the difference between depreciated cost and fair value can become substantial. This will reduce the need to sell appreciated properties to raise statutory capital.
Adjustment for Unrealized Capital Gains/Losses

- The formula for the adjusted factor would be:

\[ \text{Adj Factor} = \text{RE Factor} \times (1 - [2/3] \times (\text{MV-BVg})/\text{BVg}) \]

<table>
<thead>
<tr>
<th>BV</th>
<th>MV</th>
<th>RBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>50</td>
<td>14.7%</td>
</tr>
<tr>
<td>100</td>
<td>100</td>
<td>11.0%</td>
</tr>
<tr>
<td>100</td>
<td>150</td>
<td>7.3%</td>
</tr>
<tr>
<td>100</td>
<td>200</td>
<td>3.7%</td>
</tr>
<tr>
<td>100</td>
<td>250</td>
<td>1.3%</td>
</tr>
<tr>
<td></td>
<td>Real Estate</td>
<td>Bonds</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
<td>--------</td>
</tr>
<tr>
<td>Defined maturity value</td>
<td>No defined maturity value</td>
<td>Defined maturity value (par)</td>
</tr>
<tr>
<td>Defined cash flows</td>
<td>No defined cash flows</td>
<td>Defined cash flows</td>
</tr>
<tr>
<td>Default based on failure to make a contractual payment.</td>
<td>Statutory write-down based on assessment of a permanent impairment.</td>
<td>Risk to stat capital not affected by a change to market value</td>
</tr>
</tbody>
</table>

**Why use market value in RBC for Real Estate but not for Bonds?**

- **Risk to stat capital is affected by change in market value**
RBC Adjustment for Real Estate Encumbrances

- **Current status**: RBC is based on the total value of the real estate, with an adjustment for any encumbrance based on the RBC factor for Commercial Mortgage Loans.

- The proposed change is to update this adjustment to reflect the new RBC factors for commercial mortgage loans adopted in 2012:
  - Original average Commercial Mortgage factor: 3.00%
  - Updated average Commercial Mortgage average factor: 1.75%

- Since this is an offset to the RE factor, the lower factor produces an increase to RBC.

- The presentation is changed, but algebraically equal for the same factor.
Schedule BA: Indirect equity investments in real estate

- **Current status**: C-1 factor of 23%
  - Rationale: C-1 factor for Schedule BA is 50% more than the C-1 factor for Schedule A real estate assets to account for presumed additional risk associated with potentially lower information transparency and control within the structures as well as unknown leverage.

- **Proposal**: Factor of 12%, factor for Schedule A real estate assets (11%) plus 1% premium (10% of base factor)
  - Rationale: Data availability and industry experience has provided evidence that this premium is overly conservative, if not altogether unnecessary for the assets classified as real estate within Schedule BA. A study showed that, since 1983, real estate held through joint ventures has performed consistently with and perhaps even slightly better than, wholly-owned real estate.
  - An ACLI survey of member companies showed characteristics of Schedule BA real estate to be similar to Schedule A.
RBC for Real Estate Decisions

- What base factor should be used for company owned real estate? Proposed to be 11%.
- How much of the impact on the risk profile from the unrealized gains be reflected in the RBC? Propose a ratio of 2/3 of the gain to the BACV.
- Should the recognition of encumbrances be updated from the original CML factor of 3% to an average of the current CML of 1.75%?
- Should real estate held through a joint venture or fund receive the same factor as directly owned? If not, how adjusted? Propose to use a factor of 12%.
**Capital Adequacy (E) Task Force**

**RBC Proposal Form**

<table>
<thead>
<tr>
<th>DATE: February 26, 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTACT PERSON: Steve Clayburn</td>
</tr>
<tr>
<td>TELEPHONE: (202) 624-2197</td>
</tr>
<tr>
<td>EMAIL ADDRESS: <a href="mailto:steveclayburn@acli.com">steveclayburn@acli.com</a></td>
</tr>
<tr>
<td>ON BEHALF OF: American Council of Life Insurers (ACLI)</td>
</tr>
<tr>
<td>NAME: Steve Clayburn</td>
</tr>
<tr>
<td>TITLE: Senior Actuary, Health Insurance &amp; Reinsurance</td>
</tr>
<tr>
<td>AFFILIATION: ACLI</td>
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<tr>
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<td>Year ________</td>
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<td>[ ] REJECTED</td>
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<tr>
<td>[ ] DEFERRED TO</td>
</tr>
<tr>
<td>[ ] REFERRED TO OTHER NAIC GROUP</td>
</tr>
<tr>
<td>[ ] EXPOSED</td>
</tr>
<tr>
<td>[ ] OTHER (SPECIFY)</td>
</tr>
</tbody>
</table>

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

| [ ] Health RBC Blanks | [ ] Property/Casualty RBC Blanks | [ X ] Life and Fraternal RBC Instructions |
| [ ] Health RBC Instructions | [ ] Property/Casualty RBC Instructions | [ X ] Life and Fraternal RBC Blanks |
| [ ] OTHER |

**DESCRIPTION OF CHANGE(S)**

To update the RBC calculation for Real Estate to reflect updated experience and analysis since RBC was first developed.

**REASON OR JUSTIFICATION FOR CHANGE **

When RBC was developed, there was limited experience on the default and loss for commercial real estate. Since then data sources have been compiled and tracked in the industry, and can now be accessed to provide more meaningful analysis and information for development of capital standards.

**Additional Staff Comments:**

** This section must be completed on all forms.  
Revised 2-2019
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1. **REAL ESTATE**

**Basis of Factors**

Companies that have developed their own risk-based capital factors for real estate have used a range of factors from 5 percent to 20 percent. One study indicated real estate volatility is about 60 percent of common stock, suggesting a factor in the range of 18 percent. Assuming a full tax effect for losses, a pre-tax factor of 15 percent was chosen. Foreclosed real estate would carry a somewhat higher risk at 23 percent pre-tax. Schedule BA real estate also has a 23 percent factor pre-tax because of the additional risks inherent in owning real estate through a partnership. The pre-tax factors were developed by dividing the post-tax factor by 0.65 (0.65 is calculated by taking 1.0 less 0.35). The pre-tax factors are not changing for 2018 due to tax reform. The base factor for equity real estate of 11% was developed by adding a margin for conservatism to the results of an analysis of real estate performance over the period of 1978 – 2020. The analysis was conducted by a group of life insurance company real estate investment professionals coordinated by the ACLI. The data used was a national database of real property owned by investment fiduciaries and supplemented by data on real estate backing mortgage securities. The analysis is documented in a report to the NAIC dated February 26, 2021. In addition to modifying the factor for company owned and investment real estate, this updated factor will also be used for real estate acquired in satisfaction of debt (Foreclosed real estate). For assets with the characteristics of real held estate (partnership or other structure) reported on Schedule BA, a higher factor is used to account for the lower transparency involved with these structures. Foreclosed real estate is recognized in the statutory statements as having acquisition cost equal to market value at time of foreclosure. Schedule BA real estate was originally given a higher factor under a presumption that it was more highly levered. Analysis has shown these assets to have experience very similar to directly held and will therefore use a modestly higher factor.

While the experience analysis was done based on analysis of fair value impacts, Real Estate is reported at depreciated cost in the Statutory statements. The difference in values impacts the risk to statutory surplus. Therefore, an adjustment is made to the factor based on the difference between fair value and statutory carrying value on a property by property basis. The adjustment is defined as

\[
\text{Adj Factor} = \text{RE Factor} \times (1 - \text{factor} \times \frac{\text{MV} - \text{BVg}}{\text{BVg}})
\]

Factor is \(\frac{2}{3}\)

The resulting adjusted RBC factor is subject to a minimum of zero. In the RBC calculation, see Figure 7, fair value is taken from Schedule A Column 10 plus encumbrances, or from Schedule BA column 11 plus encumbrances, respectively, while BVg is the net Book Adjusted Carrying Value plus the encumbrance.

Encumbrances have been included in the real estate base since the value of the property is held net of the encumbrance, but the entire value is subject to loss would include encumbrances. Encumbrances receive a base real estate factor of 11% reduced by the average factor for commercial mortgages of 1.752 percent pre-tax. In the past this was computed as a base factor applied to the net real estate value plus a separate factor applied to the amount of the encumbrance. Beginning in 2021, the equivalent result will be obtained by applying a base factor to the gross statutory value of the property, and a credit provided for the amount of the encumbrance for real estate encumbrances not in foreclosure and 20 percent pre-tax for real estate encumbrances in foreclosure and encumbrances on Schedule BA real estate.

The final RBC amount is subject to a minimum of the Baa bond factor (1.30%) applied to the BACV, and a maximum of 45% of the BACV.

All references to involuntary reserves as it relates to real estate were removed to comply with the codification of statutory accounting principles.

**Specific Instructions for Application of the Formula**

Column (1)

Calculations are done on an individual property or joint venture basis in the worksheets and then the summary amounts are entered in this column for each class of real estate investment. Refer to the real estate calculation worksheet (Figure 7) for how the individual property or joint venture calculations are completed.
Line (1) should equal Page 2, Column 3, Line 4.1.
Line (2) should equal Page 2, inside amount, Line 4.1.
Line (4) should equal AVR Equity Component Column 1 Line 20.
Line (5) should equal AVR Equity Component Column 3 Line 20.
Line (7) should equal AVR Equity Component Column 1 Line 19.
Line (8) should equal AVR Equity Component Column 3 Line 19.
Line (14) should equal Schedule BA, Part 1, Column 12, Line 1299999, 2199999 plus Line 1899999, 2299999, in part.
Line (15) should equal Schedule BA, Part 1, Column 12, Line 1799999 plus Line 1899999, in part.
Line (17) should equal AVR Equity Component Column 1 Line 75.
Line (18) should equal AVR Equity Component Column 1 Line 76.
Line (19) should equal AVR Equity Component Column 1 Line 77.
Line (20) should equal AVR Equity Component Column 1 Line 78.
Line (21) should equal AVR Equity Component Column 1 Line 79.

Low income housing tax credit investments are reported in Column (1) in accordance with SSAP No. 93—Low Income Housing Tax Credit Property Investments.

Column (2)
The average factor column is calculated as Column (3) divided by Column (1).

Column (3)
Summary amounts are entered for Column (3) based on calculations done on an individual property or joint venture basis. Refer to Column (8) of the real estate calculation worksheet (Figure 7).

Line (17)
Guaranteed federal low-income housing tax credit (LIHTC) investments are to be included in Line (17). There must be an all-inclusive guarantee from an ARO-rated entity that guarantees the yield on the investment.

Line (18)
Non-guaranteed federal LIHTC investments with the following risk mitigation factors are to be included in Line (18):
   a) A level of leverage below 50 percent. For a LIHTC Fund, the level of leverage is measured at the fund level.
   b) There is a tax credit guarantee agreement from general partner or managing member. This agreement requires the general partner or managing member to reimburse investors for any shortfalls in tax credits due to errors of compliance, for the life of the partnership. For an LIHTC fund, a tax credit guarantee is required from the developers of the lower-tier LIHTC properties to the upper-tier partnership.

Line (19)
State LIHTC investments that at a minimum meet the federal requirements for guaranteed LIHTC investments.

Line (20)
State LIHTC investments that at a minimum meet the federal requirements for non-guaranteed LIHTC investments.

Line (21)
State and federal LIHTC investments that do not meet the requirements of lines (17) through (20) would be reported on Line (21).
## Real Estate Worksheet

<table>
<thead>
<tr>
<th>Description</th>
<th>Book/Adjusted Carrying Value</th>
<th>Encumbrances</th>
<th>Fair Value</th>
<th>Encumbrances credit factor</th>
<th>Adjusted RBC Factor</th>
<th>Gross RBC Book/Adjusted Carrying Value Requirement</th>
<th>Encumbrances Credit Requirement</th>
<th>RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) All Properties Without Encumbrances†</td>
<td>XXX</td>
<td>XXX</td>
<td>0.1150</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) All Properties With Encumbrances:</td>
<td>XXX</td>
<td>XXX</td>
<td>0.1150</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) All Properties With Encumbrances:</td>
<td>XXX</td>
<td>XXX</td>
<td>0.1150</td>
<td>0.01750.200</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) All Properties With Encumbrances:</td>
<td>XXX</td>
<td>XXX</td>
<td>0.1150</td>
<td>0.01750.200</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(199) Total Company Occupied Real Estate</td>
<td>XXX</td>
<td>XXX</td>
<td>0.1150</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) All Properties Without Encumbrances†</td>
<td>XXX</td>
<td>XXX</td>
<td>0.1123</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(2) All Properties With Encumbrances:</td>
<td>XXX</td>
<td>XXX</td>
<td>0.1123</td>
<td>XXX</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(3) All Properties With Encumbrances:</td>
<td>XXX</td>
<td>XXX</td>
<td>0.1123</td>
<td>0.01750.200</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>(4) All Properties With Encumbrances:</td>
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<td>0.1123</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>(299) Total Foreclosed Real Estate</td>
<td>XXX</td>
<td>XXX</td>
<td>0.1123</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(1) All Properties Without Encumbrances†</td>
<td>XXX</td>
<td>XXX</td>
<td>0.1145</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(1) All Properties With Encumbrances:</td>
<td>XXX</td>
<td>XXX</td>
<td>0.1145</td>
<td>XXX</td>
<td></td>
<td></td>
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<tr>
<td>(399) Total Investment Real Estate</td>
<td>0.1115</td>
<td>0.0175</td>
<td>0.1200</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>----------------------------------</td>
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<tr>
<td>Total Real Estate (Line (199) + Line (299) + Line (399))</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Schedule BA Assets with characteristics of Real Estate**

| (1) All Assets Without Encumbrances* | XXX | 0.1223 | XXX |
| (2) All Assets With Encumbrances:All Properties With Encumbrances: |        |        |      |
| (3) | 0.1223 | 0.0175 | 0.2000 |
| (4) | 0.1223 | 0.0175 | 0.2000 |

| (899) Total Schedule BA Real Estate |        |        |        |

Note that column (2) is the book/adjusted carrying value net of any encumbrances, while column (4) is the fair value of the property not reduced for any encumbrances.

* For each category, **each property** Line (1) should also exclude properties or joint ventures that have a negative book/adjusted carrying value. Those should be listed individually, including those for which there is no encumbrance.

† Column (7) is Column (5) times (1-factor) * (Column (4) – (Column (2) + Column (3))) / (Column (2) + Column (3))

‡ Column (86) is calculated as (Column (2) plus Column (3)) multiplied by Column (74).

§ Column (97) is calculated as Column (3) multiplied by Column (65).

* Column (108) is calculated as the sum of Column (86) minus Column (97), but not less than zero or more than Column (2), 1.3% nor more than 45% of Column (2), and not less than zero.
Proposal
Risk Based Capital for Real Estate Assets
February 26, 2021

Executive Summary

The following recommendations are the product of analyses conducted or sponsored by the ACLI, the NAIC, and industry real estate specialists. These recommendations represent the final product of discussions and deliberations that began in 2012 and are inclusive of changes meant to address questions and recommendations posed by members of the Investments Risk Based Capital (IRBC) and Life Risk Based Capital (LRBC) NAIC working groups, the American Academy of Actuaries (AAA) and other interested parties.

The objective of the recommendations described below is to ensure that the RBC assessment methodology and charges for the real estate sector more accurately reflect the sector’s underlying risks and to promote consistency with the methodology used in other asset sectors.

A. Schedule A Real Estate Factor. Update the C-1 factor for real estate assets held on Schedule A to be a base factor of 11%. This recommended factor is based on an estimated worst cumulative loss at a 95th – 96th percentile confidence level based on historical experience, which suggested a base factor of 9.5%. As was done with common stock, we used values at 2 years loss horizon. An additional 1.5% charge is recommended to account for potential disparity in individual life company real estate portfolio composition and uncertainty surrounding the longer-term implications of the COVID-19 pandemic on the commercial real estate sector. The proposed factor would be applicable for all categories of real estate reported in Schedule A of the Life and Health Annual Statement. (See Section A)

B. Unrealized Capital Gains/Losses. Adjust the based RBC factor using a ratio of 2/3 of the percentage difference between the reported fair value and statutory book value to the statutory book value. This adjustment would account for the cushion against statutory losses that is often created in real estate assets as they are held through time. The recommended RBC factor for Section A is calibrated based on volatility of market values through time. In contrast, real estate assets are reported for statutory accounting using depreciated cost. Real estate assets depreciate annually, so each year the asset’s statutory value will be adjusted downward, even though the actual market value of the asset is more likely to be increasing. This creates an “unrealized gain” that serves as a cushion that must be completely eroded as market values fall before there would be any risk of loss of statutory capital. (See Section B)

C. Encumbrances. Revise the RBC factor for real estate encumbrances following the principles of the current RBC with factors to be consistent with the commercial mortgage RBC framework adopted in 2013. (See Section C)

D. Schedule BA Real Estate Factor. Update the factor for Schedule BA real estate to 12% on a look-through basis, equivalent to the proposed factor for Schedule A (11%) plus a premium of about 10% of the amount, to more accurately reflect the risk of real estate assets reported on Schedule BA. All other mechanics would parallel the proposal for Schedule A Real Estate. (See Section D)
Scope

This proposal is developed for the Life and Fraternal Risk Based Capital formulas. This proposal does not address possible adjustment to the Asset Valuation Reserve (AVR) or tax adjustments for these assets. Finally, this proposal does not directly address the factors for the Health Risk Based Capital or for the Property & Casualty Risk Based Capital.

Background

RBC is used to measure potential future excess losses and their effect on statutory capital. The goal is to help regulators identify weakly capitalized companies, given risks that individual companies are taking. This proposal is consistent in methodology with recent RBC development work for common stock and bonds in areas such as the confidence levels for statistical analyses, while recognizing real estate’s unique characteristics.

There is limited historical perspective available on the original construction methodology supporting the currently applied RBC factors for real estate investments. The following general description is taken from a 1991 report covering RBC C-1 (default) factors:

“There is little data upon which to base requirements for this asset group. Company practice, as shown by the 1990 intercompany survey, indicates factors in the range of 5 percent to 20 percent. An article in the May-June 1991 Financial Analysts Journal (Ennis and Burk) proposes that real estate volatility is about 60 percent of that for common stock, suggesting a factor in the range of 18 percent. If one assumes full tax credit for losses, this converts to a factor of about 10 percent which is the Subcommittee’s recommendation for all real estate subcategories, except real estate acquired by foreclosure for which the factor is 15 percent. This is one of several asset groups which deserve continuing study to assure that risk-based capital requirements are adequate and appropriate.”

Since the original real estate factor estimation, which was based on the somewhat rudimentary analysis described above, there has been a very significant improvement in the availability of performance data for the sector. While there have been additional analyses conducted for this sector since the initial methodology and factor adoption (i.e., AAA proposals in September and December 2000), to date there have been no significant changes made to the C-1 factor for real estate.

Since 2000, the pre-tax base C-1 factor for real estate applied in the sector has been 15%. The derivation of this factor, as described above, was based on 60% of the common stock factor, adjusted for taxes. The logic at the time was that the volatility of real estate was assumed to be around 60% of common stock volatility. This assumption was reportedly based on inferences made from historical real estate investment trust (REIT) performance, as a robust private market performance history was not available at that time. REITs are companies that use debt in owning and managing properties and have performance characteristics different from that of the underlying commercial real estate. The same 15% C-1 factor currently applies to virtually all directly held real estate, including company occupied properties, investment properties for long-term hold, and properties held for sale, but excludes properties acquired through foreclosure which were perceived to be riskier.

It is also important to note, that while real estate is considered an equity asset, statutory accounting requires it to be valued at depreciated cost. Any capital improvements are added to the statutory book value, and then

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1 Various studies have since shown that equity real estate in general has volatility well less than 60% of that of the S&P 500.
2 The volatility of REIT performance is higher than the volatility of direct property performance primarily because REITs are leveraged investments, which results in greater volatility of results. Further, privately held property is not marked-to-market daily, trades infrequently, and tends to exhibit price changes rather slowly.
depreciated from that time. If and when there is an other-than-temporary impairment, the book value is revised down to then market value, if lower, and depreciated going forward. Throughout this document this is referred to as depreciated cost.

The real estate sector has matured significantly in the last 30 plus years, as institutional investment has become prevalent and public capital markets have become more developed. Information transparency has increased materially and the market has become much more “efficient”. Valuation and accounting policies and standards, and increased regulation, have also increased standardization and invest ability. Ownership of commercial real estate is now much more widespread across institutions, including pension funds, than in the earlier period.

A. Review of Base C-1 RBC Factor – Support for Change to 11%

Analyses conducted or sponsored by the ACLI, the NAIC, and industry specialists suggest that the base C-1 RBC factor applicable to Schedule A real estate (including investment, foreclosed and held for sale real estate) should be set at 9.5%. An additional 1.5% cushion is recommended to account for potential disparities between the composition of the index used and individual life insurance company real estate portfolios and uncertainty surrounding the impact of COVID-19 on the longer term performance of commercial real estate. This recommendation is based primarily upon the NCREIF National Property Index (NPI) Price Variation Analysis presented below.3

Note that the support presented in this Section A represents an updated methodology meant to address certain concerns expressed by the American Academy of Actuaries regarding representation of the Global Financial Crisis in the data set. The original supporting methodology and support can be found in Appendix 3, for reference only.

The primary methodology employed to determine the recommended charge is analyses based on actual historical real estate investment performance data from the NCREIF Property Index (NPI), appended by data from FRC/Kelleher to extend the series through earlier years of 1961-1977.4 This data set is collectively referred to as “NPI” in this analysis.

<table>
<thead>
<tr>
<th>Results of Price Variation Model of NCREIF Property Index (“NPI”)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>1 YR HP Cumulative Loss</td>
</tr>
<tr>
<td>95-PCT</td>
</tr>
<tr>
<td>96-PCT</td>
</tr>
</tbody>
</table>

The above table presents the results of analyses of historical NPI total return data. The table presents the results of analyses based on both 95th percentile (PCT) and 96th PCT worst results in the historical data set. Further, the table presents cumulative losses at varying periods ranging from 1 to 4 years. Historically, downturns in real estate tend to last no longer than 3 years, so this period also represents the worst cumulative decline that would be observed even if the assumed period was extended further. The “cumulative” observations represent the largest cumulative loss experienced at any point in the period.

The recommendation of 9.5% is based on consideration of the maximum cumulative losses at both the 95th and 96th percentiles (“PCT”) during the observed period. This assumed period of loss is consistent with the assumption used for common stock. Importantly, based on historical performance data for the sector, the 11% recommended base factor would cover cumulative losses during a 2-year period at a 96.8% confidence level.

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3 See Appendix 1 for a detailed description of NCREIF and the NPI.
We also note that in using cumulative losses over time, there is no discounting for time value of money, and all analysis are conducted without any consideration of the federal income tax impact of the losses.

The use of actual historic quarterly returns across 60 years of industry experience provides for the incorporation of the impact of several economic cycles on supply and demand for commercial real estate and the impact on market values. This lengthy period also allows for incorporation of the effects from earlier governmental impact on prices, such as from changes in the tax code in the 1980s.

Considerations

1. Applicability of Index to Individual Life Company Portfolios

The recommended decrease in the RBC factor for Real Estate is based on the performance of a large and well diversified commercial real estate benchmark performance index (i.e., NCREIF-National Property Index, NPI). The index includes quarterly data from all the major property types (office, retail, industrial, multifamily and hotel) across all regions of the US, which makes it broadly applicable to all of these major property types nationwide. Additionally, we compared the distribution of properties by type and by geographical region in the NCREIF database to the distribution of those held by the life insurance companies and found the distributions to be quite similar.

The question of the potential need for increased granularity for the RBC factor was considered thoroughly. In particular, we considered a different factor for company occupied as a class with lower risk than investment properties. However, granularity beyond the single factor representative of all US commercial real estate was deemed inappropriate due to 1) the relatively small size of the asset class, 2) the alignment of composition between the NPI and the life industry portfolio, and 3) regulations separate from RBC factors that address concentration risks and assure diversification of life company real estate portfolios.

Additionally, segmenting the NPI dataset into smaller granularities can be problematic. The NPI as of 2nd Quarter 2013 consisted of just over 7,000 properties but roughly 30,000 properties have been in the index at some point during its 30+ year history. Over that history, the geographic and property type distribution of NPI has been constantly evolving. While the database of properties is large in total, segmenting it into more granular levels can produce sample sizes too small to be statistically sound. Beyond this, segmenting can add only limited additional value. The primary driver of real estate property performance is the national real estate cycle as portrayed in the NPI. The pattern of real estate losses for both the industry and for individual companies is aligned with that cycle. In other words, the overall real estate cycle tends to dominate other effects including geography and property type. The strength of that national real estate cycle has been found in academic research to explain roughly 50% of the variation in property performance across all properties in the index.

2. Impact of Select Key Assumptions

- **Loss Horizon:** The period of time assumed for the accumulation of losses in the analysis (loss horizon) plays an important role in determining the appropriate amount of required capital. In this updated proposal, we suggest an 11% RBC factor, which is based on cumulative losses over 3 years. Real estate assets are typically held longer-term, often five years or greater. As the assets are more illiquid than publicly traded bonds or other securities, they are often used to back surplus, or longer-term liabilities. Liquidity is managed such that the timing of sale of real estate assets can often be strategically determined, thus

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avoiding realization of the larger maximum potential losses. The key focus is the length of economic cycles with losses. In past real estate cycles, the duration of losses typically spans a 2 to 3-year period, with the majority of losses during past downturns being materially concentrated within one year. Average holding periods for real estate assets are typically much longer than one year, averaging 10 years or longer, based on analysis periods and investment targets for most institutional investors. As such, and given the statutory accounting for the asset class with declining book value and rigorous impairment requirements, it is normal for the actual recognized impairment rates by insurance companies to be lower in both frequency and severity than market averages. This is primarily related to the existence of unrealized gains that must be exhausted prior to any recognition of losses.

- **Confidence Level:** The confidence level also plays an important role in determining the appropriate amount of required capital. The 9.5% suggested base factor generally corresponds to the losses modeled at between the 95th and 96th percentiles (PCT) over a worst cumulative period. The recommended 11% factor covers losses at a 96.8% confidence level, assuming maximum cumulative losses during a 2-year period.

- **Reserve Offset:** The development of the bond factors includes an offset for expected losses based on the principle that expected losses are covered by reserves. Real estate and common stock are both treated as equity assets which are generally to support surplus and not reserve, and for which expected loss is not considered. The current RBC methodology for real estate equity does not include an offset for the expected loss, as the basic contribution to AVR used as a proxy for expected loss is zero. Similarly, this proposal does not include an offset for expected loss.\(^6\) The rationale for excluding the mitigating effects of the expected loss include:
  - There is no basic contribution to AVR for real estate investments.
  - Real estate is a small asset class, and analyses required to develop appropriate offsets for expected loss are deemed unnecessary.
  - Discussions around the appropriate relationship between expected loss, AVR, and RBC are ongoing. In the future, as precedent is set in the other larger asset classes where the effects are likely even more important, the potential integration of an offset in the real estate equity sector should be reconsidered.

- **Income:** In the development of RBC factors for bonds, income in excess of the expected loss offset discussed above is not included in the modeling and is assumed to be used for policyholder liabilities and not available as a loss offset. For common stock, and for real estate as equity investments, the total return is used. First, since the equity assets are generally presumed to back surplus and not policyholder reserves, the policyholder does not have claim to the income. Consistent with the lack of offset for expected loss, the income is available. When bonds default there is no subsequent income available to the investor. Real estate does not default, and even if subject to impairment, continues to produce income. The real estate values were therefore developed consistent with common stock using a total return view of the assets.

- **Taxes:** All of the modeling discussed in this project was done on a “cash” basis. No consideration has been given to the effect of these losses on the tax liability of the investor. Since losses reduce taxes that otherwise would be paid by the investor, this will result in a lower post-tax RBC factor than the recommended level.

- **Property acquired through foreclosure:** Property acquired through foreclosure should be treated the same as any other real estate. If the insurer forecloses on a mortgage and obtains the property, statutory

\(^6\) There are currently discussions at the NAIC regarding whether RBC assessments should be adjusted to remove the expected losses for sectors. In real estate equity’s case, we are uncertain as to the materiality of adjusting for expected losses. The same could be said for common stock, as expected loss is a fixed income concept and would be difficult to apply to equities.
accounting requires the property to be brought onto the company’s books at then current market value. As a result, the value is no different than any other property purchased in the course of business. If the property has low income potential, that will be reflected in its market value.

3. Application of Stochastic Approaches

While we considered stochastic approaches, a fully stochastic model was deemed inappropriate by the working group due in large part to the limited amount of quarterly historical observations (limited when compared to the amount of daily transaction data available for public stocks and bonds). It is possible that a stochastic analysis could be performed wherein an algorithm would be built and calibrated to actual history.

However, if the algorithm is calibrated to historical performance, we believe that the results of such an analysis would be consistent with our work, which includes periods of very significant market stress in the sector. Note that the work performed in both common stocks and bonds excluded significant periods of stress in those markets, given changes in the economy from the advent of the creation of the Federal Reserve. Both asset classes have public data going back to early in the 19th century, though of varying quality. We used the full historic track record for Commercial Real Estate (CRE) that is available and includes the downturn in CRE from the S&L crisis in the 1990s, the effects of the dot-com bubble, the global financial crisis and the most recent effects of COVID-19 pandemic in 2020.

B. Adjust RBC to recognize risk impact of unrealized gains and losses

We also recommend implementation of an adjustment to individual property RBC that will account for the cushion against statutory losses that is often created in real estate assets as they are held through time. The RBC factor that is recommended in Section A is calibrated based on volatility of market values through time. However, real estate assets are reported for statutory accounting using depreciated cost. In real estate, the assets depreciate annually, so each year the asset’s statutory value will be adjusted downward, even though the actual market value of the asset is more likely to be increasing. Annual depreciation rates in real estate are often 2% or higher. This creates an “unrealized gain” that serves as a cushion that must be completely eroded as market values fall before there would be any risk of loss of statutory capital.

Fair value of real estate assets held by life companies is reported in Schedule A for each individual property. This fair value includes the changing market value of the asset and the impact of any improvements that have been capitalized. This excess of market value over the statutory value is a cushion against loss of statutory capital.

We propose that the applied base RBC factor be adjusted using a ratio of 2/3 of the percentage difference between the reported fair value and statutory book value to the statutory book value. That value applied to the gross book value and after being reduced for any encumbrance would be floored to the RBC using the NAIC bond factor for a Baa equivalent (currently 1.30%) applied to the BACV. Note that in situations where fair value is less than statutory, the RBC factor will be increased.

Examples of the application of the adjustment are presented in the below table and are hypothetical. If a market value were lower than book value, that property would be reviewed for possible impairment. If the value were down temporarily, this adjustment would provide a short-term increase in RBC. If the value is down on a permanent basis, this may provide an early increase in RBC prior to taking an impairment.

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7 See Appendix 2 for sample calculation.
The specific formula including adjustment would be: 

$$RBC\% = \max \left[ NAIC2\%, 11.0\% \times \left( 1 - \frac{2}{3} \times (MV - BVg) / BVg \right) \right]$$

<table>
<thead>
<tr>
<th>BV</th>
<th>MV</th>
<th>RBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>50</td>
<td>14.7%</td>
</tr>
<tr>
<td>100</td>
<td>100</td>
<td>11.0%</td>
</tr>
<tr>
<td>100</td>
<td>150</td>
<td>7.3%</td>
</tr>
<tr>
<td>100</td>
<td>200</td>
<td>3.7%</td>
</tr>
<tr>
<td>100</td>
<td>250</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

BVg is the book value gross (prior to netting the encumbrances); NAIC2 is the NAIC2 corporate bond RBC charge.

In an effort to assess the effects of statutory accounting on actual life insurance company experience, a simulation was constructed to analyze hypothetical life company portfolio performance given statutory accounting. The results of this study demonstrate the materially lower statutory losses as compared to market value losses during downturns, and thus provide support for the proposed adjustment.

In 2013 the ACLI, NAIC, and Industry real estate specialists engaged Jeff Fisher (Academic Consultant), who is a special academic consultant to NCREIF, to use the historical property level performance data in the NPI to construct simulated historical performance under statutory accounting rules. The analysis leveraged all available NPI data history at the required level of granularity at that time, which included the period of 1978Q2 through 2013Q1. This analysis was performed to provide additional insight around the impact of statutory accounting (recognition of depreciation, impairment rules, etc.) on the historical performance and risk to capital for insurance companies.

The simulation used the actual historical market experience of the NPI at the individual property level, wherein estimates of statutory accounting were applied. This hypothetical exercise was not intended to serve as the primary basis for determination of an appropriate RBC factor. Rather, the results of this hypothetical exercise illustrate the effect that statutory accounting (i.e., with depreciating book values and impairment rules/requirements) can have on the timing and severity of loss recognition relative to market value changes and provide additional evidence that the primary analysis is reasonable, if not conservative, given the effect of statutory accounting.

The simulation made the following assumptions:

1. Beginning Book Value for statutory accounting when properties enter the data set is set equal to then current market value.
2. For Book Value projections, depreciation is over 20 years (5% per year) for all properties.
3. Properties are tested for impairment quarterly, with impaired properties removed from index after recognizing the loss from the impairment. Any income received to that point is retained in the modeling.
4. As in statutory accounting, there is no accounting for property value increases, only losses are recognized in the analysis.
5. There is no offset related to expected loss (i.e., there is no accounting for AVR).

**Example of Simulated Statutory Property Performance:** In the simulation, individual asset market values are recorded in the quarter a property enters the index. At this beginning quarter, book value is set equal to market value, which is assumed to be the cost to acquire and is therefore consistent with statutory accounting. Every
quarter forward, NCREIF has updated estimates of market value for the asset.\(^8\) Future statutory carrying value of the asset (depreciated book value) is estimated using the generic depreciation assumptions listed above. In every quarter, we estimate whether an impairment would have been recognized using statutory accounting rules, the then current market value, anticipated future property cash flows as implied from that market value, and then current statutory carrying value. Aggregate impairment rates by quarter are tracked through time, which are useful for comparison to actual market value losses reported for the index.

Using the above assumptions in the simulation model and including all properties over the entire history of the NPI, the following chart presents quarterly total losses as a percent of market value. As the chart below illustrates, the largest quarterly loss rate for the simulated index performance was just slightly over 2% during the recent Great Recession. Further, over this entire simulated history there are only a few quarters with significant simulated statutory losses. Losses were concentrated in the real estate market downturns of the early 1990s and in 2009 following the Great Recession.

The largest one-year loss for the full history of the simulated data occurred during the Great Recession, when the simulated one-year cumulative statutory loss was approximately 7% during the year 2009.\(^9\) During 2009, the actual recorded total return for properties in the NPI was a cumulative loss of 17%. This decline occurred amid the most severe downturn in history, based on its intensity. However, the value decline during this period was relatively short-lived, as the negative quarterly total returns persisted for only six quarters.

Given the event was an extreme outlier in the history of real estate performance, the probability of it reoccurring is extremely low within the modeled random sampling. In simple terms, since the 17% decline in one year occurred once in the 36-year exposure, the implied frequency is 2.8% probability (i.e., one year out of 36) while RBC is set to a 5% (or 95% confidence) level. In addition, this temporary reduction in market value would not necessarily have led to equal statutory impairments both since market value is typically in excess of book value, and requirements for statutory impairments do not immediately recognize all changes to market price. Thus, statutory accounting can lessen the severity of recognized losses during market downturns.

\(^8\) The NCREIF database relies on appraisals to establish value where there has not been a transaction. The simulation projected MV could be viewed as projected appraised value. Various studies of CRE appraisals have been performed and show that the appraisals are good estimates of MV, though they may lag actual market changes. This assumption does not affect the validity or applicability of the results.

\(^9\) While the 7% maximum simulated loss should provide a degree of comfort in the reasonableness of the proposed factor, it is not directly comparable in concept to either the proposed factor or the cited actual historic market value based index returns.
As further evidence of the impact of statutory accounting, we examined actual losses incurred during the Global Financial Crisis, which is the most severe real estate market downturn within the 60-year data analysis period. The ACLI conducted an analysis of the life insurance industry’s actual performance during 2008 through 2012. The analysis examined all impairments of real estate investments, along with recognized losses on sale of real estate investments, during the period using data from Annual Statement exhibits Schedule A Parts 1 and 2. The industry reported cumulative losses of about 3.5% over that 5-year period, significantly lower than the 9.5% recommended factor. These reported industry losses include Other-Than-Temporary Impairments and losses on sale as reported in the Annual Statement schedule. Note that the analyses did not account for the declines in value of assets that are reported at fair value for statutory purposes.

C. Update RBC charge on real estate encumbrances

Under Statutory Accounting rules, real estate is held at depreciated cost net of encumbrances. Under the current proposal, RBC will be assessed by estimating the risk on the total property, then providing a credit for the value of the encumbrance based on the equivalent risk of the mortgage. The rationale for this is that the total underlying risk of loss on the property is the same whether or not there is an encumbrance, but the holder of the encumbrance bears part of the risk and the holder of the property bears the balance. Therefore, the risk is split effectively by developing the risk for the entire real estate value, then subtracting the amount of risk ascribed to the mortgage. We chose the approach of a reduced factor based on the average factor for mortgages in light of the small size of the real estate asset class, and the even smaller amount of encumbrances. For implementation, we recommend changing the RBC worksheet to show the RBC for the entire real estate, then a credit for the amount of the encumbrance. The final RBC will be subject to a minimum of the NAIC factor for a Baa bond (currently 1.30%) of the net book adjusted carrying value of the real estate, and not more than 45% of the net book adjusted carrying value.

The current encumbrance factors were based on the current RE factor of 15% reduced by the average RBC for commercial mortgages, which was 3.00% under the prior RBC formula. The proposed factor for Real Estate is 11.0%, and the average commercial mortgage factor that was developed as part of the Commercial Mortgage proposal in 2013 was 1.75%. As an example, consider the following:

<table>
<thead>
<tr>
<th>Property Value</th>
<th>Amount</th>
<th>RBC factor</th>
<th>RBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>No encumbrance</td>
<td>100</td>
<td>11.0%</td>
<td>11.0</td>
</tr>
<tr>
<td>With 60% LTV mortgage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Property Value</td>
<td>100</td>
<td>11.0%</td>
<td>11.0</td>
</tr>
<tr>
<td>- Equity value</td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Encumbrance</td>
<td>60</td>
<td>-1.75%</td>
<td>-1.05</td>
</tr>
<tr>
<td>- Real Estate RBC</td>
<td>40</td>
<td>24.9%*</td>
<td>9.95</td>
</tr>
<tr>
<td>- Mortgage RBC**</td>
<td>60</td>
<td>1.75%</td>
<td>1.05</td>
</tr>
<tr>
<td>- Total</td>
<td>100</td>
<td></td>
<td>11.0</td>
</tr>
</tbody>
</table>

* Equals the RBC value (9.95) divided by the real estate equity value (40).
** This is an estimate of the value of the risk attributable to the mortgage by assuming that the mortgage was held by a life insurance company and estimating the resulting RBC.

This table illustrates our suggestion that the same amount of total capital be held whether a property is held with no encumbrance, or if it has an encumbrance, to reflect the constant level of risk of loss at the property irrespective of the capital stack. The RBC calculated on the encumbrance derives from the price risk of the
property. It is to reflect that there is more risk as a percent of the equity investment, though not in total risk, to the equity investment of an investor in a property when leverage is used compared to when there is no leverage and a property is owned outright. In the case of having an encumbrance, the RBC held by the lender, when added to the RBC held by the owner on its equity and its encumbrance, sum to the same amount as if the property was held with no encumbrance.

In the current RBC, the result of this formula on encumbrances includes a maximum amount equal to 100% of the book adjusted carrying value of the real estate. While recognizing the loss is generally limited to 100% of the carrying value, we believe that an RBC factor of 100% is excessive, and that the limit should be set at 45% of the carrying value. We note that for common stock, the combined factor at the maximum Beta is 45%.

D. Update Schedule BA Real Estate Factor

Real Estate held in joint ventures (JVs), limited liability companies (LLCs) or similar structures are recorded in Schedule BA, on lines 2199999 and 2299999. Currently, these assets are assessed RBC with a factor (23%) that is 50% higher than the factor for wholly owned real estate reported in Schedule A. The documentation for Schedule BA assets from the original RBC development articulates a premium over the RBC for Schedule A assets to account for additional risk associated with potentially lower transparency and control within the structures. However, since that time, data availability and industry experience has provided evidence that this premium is overly conservative, if not altogether unnecessary for the assets classified as real estate. We propose that the factor for Schedule BA real estate be adjusted to 12%, equivalent to the proposed factor for Real Estate recorded on Schedule A (11%) plus a premium of about 10% of that amount for conservatism. All of the other mechanics and components described above for Schedule A real estate would also apply consistently for the real estate recorded on Schedule BA. This proposal is supported by the following:

- Real estate investments today are very often executed through corporate structures such as LLCs simply to mitigate risks. Institutional investors regularly use these structures to reduce the risk of loss from contingent liabilities. Contingent liabilities could be associated with the operations of the property (e.g., slip-and-falls), disputes with vendors or tenants, or debt. LLCs insulate investors from losses above the value of the net equity in an individual investment. Institutional investors also often use LLCs as holding companies for a series of single-asset LLCs, in order to better organize a portfolio in a manner that limits liabilities along each level of the corporate ownership structure.

- The NAIC recently approved the reclassification of certain wholly owned single owner, single asset LLCs to be reported on Schedule A. This was due to the recognition that the LLC structure itself did not produce additional risk. In this approval, the NAIC also agreed that additional reclassification could be proposed and approved when additional supporting materials were submitted. Rather than seeking a change in the accounting, we are proposing to adjust the RBC to reflect the risk.

- Partnership structures are often used to align interests between the life insurance company and local partners who have superior access to the market and property development, asset management and property management skills, while still maintaining control of significant investment decisions, especially around liquidity. This better execution and alignment of interest can result in better investment performance and even lower market risk.

- Partnership structures reduce the capital commitment of the life insurance company to an individual transaction, and thus can add portfolio diversification.
A study was performed to compare the actual realized risk of institutional real estate investments held through JV’s to those of directly-held real estate investments. Jeffrey Fisher, Ph.D. and consultant for NCREIF, broke down all properties in the NCREIF Property Index into joint venture and wholly owned properties to compare the performance since 1983. Mr. Fisher’s analysis found as follows:

- Since 1983, the average quarterly return for JV properties was 2.35% versus wholly owned properties at 1.97%. This performance gap widened over time.
- The standard deviation of returns for JV properties (2.4%) was only modestly higher than the standard deviation of wholly owned properties (2.2%).
- Values of the wholly owned properties fell more than the values of JV properties from peak-to-trough during the Global Financial Crisis (GFC).
- In terms of return dispersion during the GFC’s worst quarter, wholly owned properties had the largest negative return and JV properties had the highest positive return.
- JV properties were found to have shorter average holding periods than wholly owned properties, suggesting potentially higher liquidity in JV structures.

In summary, real estate held through joint ventures has performed consistently with and perhaps even slightly better than, wholly owned real estate. Based on this research, and in recognition of the several legitimate risk/return benefits of ownership through structures, we propose that real estate held on schedule BA use the Schedule A factor (11%) plus a premium of 10% of that amount, totaling approximately 12%.
Appendix 1

The historical National Council of Real Estate Investment Fiduciaries (NCREIF) database goes back to December 31, 1977, and as of 2nd Quarter 2013 consisted of approximately 7,000 properties. NCREIF collects 67 data fields each quarter that consist of financial information such as Market Value, NOI, Debt, and Cap Ex, as well as descriptor data such as Property Type and Subtype, Number of Floors, Square Footage, Number of Units, and Location.

The flagship index of NCREIF is the NCREIF Property Index (NPI), which is a quarterly index tracking the performance of core institutional property markets in the U.S. The objective of the NPI is to provide a historical measurement of property-level returns to increase the understanding of, and lend credibility to, real estate as an institutional investment asset class. The NPI is comprised exclusively of operating properties acquired, at least in part, on behalf of tax-exempt institutions and held in a fiduciary environment. Each property’s return is weighted by its market value. The NPI includes properties with leverage, but all returns are reported on an unleveraged basis. The NPI includes Apartment, Hotel, Industrial, Office and Retail properties, and sub-types within each type. The index covers all regions of the US, which makes it broadly applicable to all of these major property types nationwide. Additionally, we have also done a comparison of the distribution of properties by type and by geographical region between those in the NCREIF database and those held by the life insurance companies and found them to be quite similar.

Over the history of the NPI data, there have been two severe downturns, in the 1990s and the recent GFC; as well as a shallow recession corresponding to the 2001 economic recession that did not produce negative total returns for real estate. Given the time series of the data, the index does reflect ‘tail events’ such as the Great Recession thus appropriately capturing the downturn in the employed primary methodology for estimation of the appropriate RBC charge.

Additional information on NCREIF and the NCREIF Property Index (NPI) can be found here: https://www.ncreif.org/public_files/NCREIF_Data_and_Products_Guide.pdf
Appendix 2

The difference between market value and statutory value (depreciated cost) is not included in surplus within statutory accounting. As a result, the risk of future impairments of statutory value would be much less for a company where the current market value of its portfolio of properties is well in excess of statutory carrying value, especially compared to one where market value is much closer to statutory carrying value.

Our primary analysis was based on market values, and therefore overstates the risk relative to statutory accounting. We are not proposing that statutory accounting for commercial real estate should change, but rather partially leveling the playing field for properties that have been held for extended periods with market value well in excess of statutory carrying value, versus recent acquisitions with no such unrealized gains. And we are proposing a floor charge equal to that for an NAIC 2 bond (currently 1.30%) so that capital will never be lower.

The following provides a numerical example. Assume a property held at a book value of $100 with a market value of $150. The NCREIF data measures changes in market value, and the 11% proposed factor would make provision for a loss of value to a value down to $133.50. Under the RBC process, factors are applied to the book value and normally do not recognize that unrealized gain. Since real estate is held at book value which in this case is $100, and is below this market value, effectively there an increased margin against the loss of statutory capital in excess of the amount of RBC.

For an asset with a market value well in excess of the carrying value, the reduction in RBC is minimal compared to the large-implied reserve. Similarly, in those relatively few circumstances where an asset will have a market value less than book value, the RBC amount would increase, to reflect the increased likelihood of a loss to carrying value. This increase in RBC would likely be in advance of an actual impairment, which would provide earlier visibility and recognition of weakening market conditions.
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Feb. 11, 2021. The following Working Group members participated: Philip Barlow, Chair (DC); Steve Ostlund (AL); Thomas Reedy (CA); Deborah Batista (CO); Wanchin Chou (CT); Sean Collins (FL); Vincent Tsang (IL); Mike Yanacheak (IA); John Robinson (MN); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner (TX); and Tomasz Serbinowski (UT).

1. Discussed the Moody’s Analytics Report on Bonds

Amnon Levy (Moody’s Analytics) presented Moody’s Analytics’ report on the proposed revisions to the risk-based capital (RBC) C-1 bond factors (Attachment Three-B1) and as summarized in the accompanying PowerPoint presentation (Attachment Three-B2).

Mr. Levy discussed the background of the project and why Moody’s Analytics was chosen as detailed on Page 5 of the PowerPoint presentation. He discussed the request for proposal (RFP) requirements, which were to assess the proposed required capital factors for the default risk on bonds, Moody’s Analytics’ objective opinion and its practical recommendations. He then discussed the factors that the American Academy of Actuaries (Academy) proposed.

Mr. Levy noted the defined scope of the project the Academy was given from the NAIC, which was limited to updating the data given that the bond factors were estimated some time back along with an expansion to 20 designations, recognizing that the six designations were too course and maintaining the modeling structure that was designed 30 years ago. He said the report is not limited to that defined scope but takes a much broader view, recognizing that the markets, techniques and data have evolved with capital markets. He presented Moody’s Analytics’ key findings, which include areas of concern with regard to best practices with data and modeling choices, as well as model documentation both within the defined scope and outside of the defined scope. These are detailed in Pages 9–11 of the presentation.

Mr. Levy discussed the next steps Moody’s Analytics is proposing, which include: 1) the phase 1 delivery of factors for exposure before April 30; and 2) a longer-term phase 2, which addresses modeling and data updates outside the defined scope.

As a reminder, Mr. Barlow said the Working Group was given direction by the Financial Condition (E) Committee to have new bond factors for 2021 and to take into consideration analysis prepared by the consultant for the American Council of Life Insurers (ACLI). He said his plan is to have new factors proposed for 2021 while providing as much support as possible to the consultant on their work to try to provide factors for the Working Group to consider within the necessary time frame. However, he said he believes it is an incredibly aggressive time frame for producing something as significant as new alternative bond factors, exposing them for comment, getting consensus and considering them for adoption.

Given that, Mr. Barlow proposes moving ahead with the work from Moody’s Analytics to see what it develops but also move forward with the proposed factors from the Academy so that the Working Group can expose both before the end of April. He said the Investment Risk-Based Capital (E) Working Group discussed the Academy’s factors before the tax law change, so they will need to be updated. He said he would also propose a state insurance regulator modification to the portfolio adjustment to address concerns that it could be onerous to small insurers.

2. Exposed the Alternatives for the Requested Modification to the Mortgage Reporting Guidance

Mr. Barlow said a request was received from the ACLI and the Mortgage Bankers Association (MBA) (Attachment Three-B3) to extend the guidance that the Working Group issued in 2020. He said two alternatives have been drafted, one modifying the original guidance document and one presenting the change as a new document.

The Working Group agreed to expose both alternatives for a 10-day public comment period ending Feb. 22.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
Assessment of the Proposed Revisions to the RBC C1 Bond Factors

Prepared for and the

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Moody’s (NYSE:MCO) is a global integrated risk assessment firm that empowers organizations to make better decisions. Its data, analytical solutions and insights help decision-makers identify opportunities and manage the risks of doing business with others. We believe that greater transparency, more informed decisions, and fair access to information open the door to shared progress. With over 11,400 employees in more than 40 countries, Moody’s combines international presence with local expertise and over a century of experience in financial markets. Learn more at moodys.com/about.

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Throughout this document, “Moody’s” rating refers to an MIS rating. And while this report references MIS, it is written by and reflects the views and opinions solely of Moody’s Analytics.
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1 Executive Summary

This report follows in response to the awarded request for proposal (RFP) put forth on October 22, 2020 by the American Council of Life Insurers (ACLI) in conjunction with the National Association of Insurance Commissioners (NAIC). We document Moody’s Analytics objective assessment of the proposal for updating RBC C1 bond factors (the C1 Factor Proposal), including the modeling process, the development of assumptions from underlying experience, and related adjustments to reflect the diversification of individual company portfolios used in investment risk factors for fixed income assets, as documented in the Model Construction and Development of RBC Factors for Fixed Income Securities for the NAIC’s Life Risk-Based Capital (RBC) Formula, by the American Academy of Actuaries (the Academy) C1 Work Group (American Academy of Actuaries, 2015), under the instruction of the NAIC’s Life RBC Work Group.1

In addition to providing a comprehensive review of the underlying data, assumptions, methodologies, their resulting potential biases, and their materiality, this report provides a set of practical recommendations to better quantify the identified risks intended to be captured by the RBC C1 bond factors (C1 factors). We recognize that the C1 factors, and thus the models that underpin those factors, can impact business decisions, which ultimately impact solvency. Recommendations will be based on data and modeling approaches recognized as best practice, demonstrate past performance, and rest on sound model risk management guidelines, specifically model validation that includes back-testing and performance benchmarking.2

Before proceeding with our recommendations, Moody’s Analytics recognizes that the scope of the Academy’s work was defined by the NAIC RBC Working Group (the Defined Scope). This report does not, generally, consider the “time, budget and complexity constraints” faced by the Academy in their referenced report (American Academy of Actuaries, 2015). We also recognize that this report does not generally consider the direct or indirect costs of adopting any of the recommendations into the RBC framework and related practicalities. These costs include devoting resources to develop and implement models, data collection, model maintenance, and costs encompassing expertise, governance, and control mechanisms, such as policies and procedures, controls and compliance to ensure proper model use, and implications for organizational structure — at life insurance companies or the NAIC.3 Rather, as specified in the RFP, this report focuses on the considerations, assumptions, and methodologies used by the C1 Factor Proposal and the extent to which the C1 factors capture the risks outlined above.

With these observations in mind, this report identifies two areas of potential concern that make us question the effectiveness of the proposed C1 factors, considering the possible impact on business decisions and solvency that are further discussed in Table 1, Table 2, and Table 3.

1. The use of best practices with data and modeling choices. This includes items within the Defined Scope, as well as items outside of the Defined Scope, that Moody’s feels are relevant and material. In particular:
   a. The C1 RBC base factors were estimated using an economic state model that does not lend itself to capturing properties and overcoming limitations associated with the default and recovery rate data.
   b. The lack of differentiation across asset classes (corporate, structured, and municipal credit, for example), maturity, and investment income offsets.
   c. Overly conservative assumption for the risk premium, as well as dated discount rate and tax assumptions.
   d. The use of construction of representative portfolios and the separate analysis of each rating category.
   e. The use of multiple NRSROs given their comparability.
   f. Lack of consideration of climate hazards or emerging risks (e.g., pandemic or cyber) that may not be explicitly incorporated into NRSRO ratings and may not be reflected in the historical data used in estimating C1 factors.

2. Model documentation, including model validation and limitations and general prudent model risk management. This is critical for ongoing model monitoring and model updates. With limited articulation of model limitations, the potential for distorted business use and implications for solvency warrants further investigation into the proposed factors. The lack

1 In addition, this report relies on supporting documentation of the development of assumptions and modeling processes, updated recommendations (American Academy of Actuaries, 2017), and stakeholder feedback.
2 While (American Academy of Actuaries, 2015) contains Appendix G – Model Validation, Moody’s Analytics is not aware of a report that provides a comprehensive assessments of model performance against historic losses or benchmarks.
3 For guidance on sound model risk management, please see (Board of Governors of the Federal Reserve System and Office of the Comptroller of the Currency, 2011) and references therein.
of documentation and validation related to the portfolio adjustment function and its material impact on C1 factors stands out in particular.

Moody’s Analytics is aware of the significant effort involved in creating a broader redesign of the C1 factors. Thus, we suggest phasing-in model development and implementation, data collection, model maintenance, and governance processes. Given the tight April 2021 deadline, Moody’s Analytics suggests a Phase 1 redesign that focuses on the portfolio adjustment function and the “slope” of charges across credit ratings (addressing a number of the inputs and elements of the modeling discussed in this report), adhering to the model risk management practices referenced in this report. In addition, Phase 1 should include an articulation of model limitations related to the other items referenced in this document at a level of detail and adhering to a timeline to be determined jointly with stakeholders. Phase 2 would address items that require a longer timeline and would be determined jointly with stakeholders. While we do not expect completion of Phase 2 in 2021, Moody’s suggests starting Phase 2 as soon as practical, prior to completion of Phase 1, recognizing the lead time needed for data collection and research. We discuss further details at the end of this document.

Table 1 and Table 2 present the Summary of Moody’s Analytics Significant Areas of Review and Recommendations of Key Inputs and of the modeling framework that cover Moody’s Analytics understanding of the Defined Scope. The recommendations reflect the evolution of new data and techniques that can better describe credit risk since the original C1 factors released in 1992. The recommendations also reflect the increase in size and complexity of life insurance exposure to credit and, therefore, credit risk — in lock-step with credit markets themselves. 4 The recommendations are also influenced by how other regulators, globally, have continued adopting new guidelines to better manage the risks related to growth in credit markets, with an eye toward regulatory arbitrage that is recognized to potentially distort business decisions and solvency. 5 The recommendations recognize constraints that are cited in the C1 Proposal (American Academy of Actuaries, 2015): (1) RBC must be an auditable value, calculated from published financial statements; (2) the C1 component must be based on the credit ratings reported in the NAIC Annual Statement; and (3) the C1 component must represent the statistical safety level prescribed by the NAIC. Essentially, the recommended C1 factors have been developed using a similar methodology to the current factors. Moreover, no single improvement should be made in isolation without consideration of the overall implications of the change, recognizing the overall objectives of C1 factors and potential implications for business decisions that can ultimately impact solvency. Moody’s arrives at these conclusions objectively and independently.

Table 3: Summary of Moody's Analytics Significant Areas of Review and Recommendations of Key Inputs

| Default Rates | The methodologies used by the C1 Factor Proposal to construct default rates across ratings, as well as methodologies used in differentiating default rates across expansion and contraction states, face data limitation challenges. Moody’s recommends updating the methodologies and using additional data referenced in the review that have been demonstrated to better capture credit dynamics. |
| Recovery Rates | The C1 Factor Proposal’s method used to recognize the recovery date does not align with the date of default. This deviation can result in bias with recovery rate levels, as well as their relationships with default rates. Moody’s recommends exploring the use of more accurate data and groups when describing recovery distributions and utilizing more current techniques that link recovery with the credit environment. |
| Discount Rate | Since the modeling work was conducted by Academy in 2015, the discount rate used in the model is calculated using historic data that does not reflect the current low-interest environment, nor the expected continuation of a low interest rate environment. Moody’s Analytics recommends updating the discount rate to include December 31, 2013 – December 31, 2020 data to better reflect the current and expected interest rate environment, in conjunction with updated tax assumptions that reflect the 2017 Tax Act. |
| Construction of the Representative Portfolio | The segmentation and filtering of the sample portfolios used to construct the representative portfolio lack economic justification or sensitivity analysis. For example, for reasons not explained, only NAIC1 and NAIC2 rated issuers are used to determine the number of bonds in the representative portfolio for all rating categories. In addition, each representative portfolio ultimately used in the simulation contains one rating category, which makes the final C1 factors heavily dependent on portfolio adjustment factors. Given the importance of the representative portfolio, we recommend more comprehensive documentation and |
In reviewing the C1 Proposal, Moody’s Analytics found several aspects to the underlying modeling and data that were outside of the Defined Scope worth incorporating into this report, included in Table 3.

### Table 3: Summary of Moody’s Analytics Significant Areas of Review and Recommendations of Modeling Framework

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tax Assumptions</strong></td>
<td>The U.S. corporate tax rate was lowered from 35% to 21% in accordance with the 2017 Tax Reconciliation Act (Deloitte, 2018). Net capital gains included in the taxable income are subject to the 21% rule (CCH Group, 2019). While the model was developed based on historical data before the tax cut, the RBC factors, if adopted, will be applied to insurers, which will pay the updated tax rate. It will be worthy to consider updating the assumed 35% tax rate to 21%. Moody’s recommends analysis reflecting the current tax environment.</td>
</tr>
<tr>
<td><strong>Portfolio Adjustment Factors</strong></td>
<td>The portfolio adjustment factor is one of the most important elements of the model, as it ultimately determines the general RBC level for individual insurers. Unfortunately, documentation is limited, making it difficult to access the materiality of some of the modeling choices. In addition, the limited documentation available suggests a potential material gap between the calculated C1 factor and its target level for individual insurers, especially smaller ones. Moody’s recommends: (1) more detailed documentation of the adjustment factor and the underlying economic justification, in conjunction with the doubling of C1 factors for the top-10 largest issuers; (2) further exploring the data and methods used to estimate the portfolio adjustment factors, to ensure they are effective for corporate as well as non-corporate issuers. (3) design the factors to align incentives with the economic risks, and (4) design a structure that brings together the portfolio adjustment factors along with the doubling of C1 of the 10 largest issuers.</td>
</tr>
<tr>
<td><strong>Risk Premium</strong></td>
<td>The current assumption of setting the Risk Premium equal to expected loss appears to be overly conservative. While the C1 Factor Proposal recognizes the inconsistency, they point out that the 1992 guidelines defined the Risk Premium in this way and, in conjunction with other parameters, some of which (e.g., AVR) are beyond the scope of this report. While Moody’s appreciates the desire to incorporate conservativeness into assumptions, inputs for which accurate proxies are available should be directly used, and rather incorporate the conservative overlay into the final steps to facilitate model transparency. Moody’s recommends a broader evaluation of the various interconnected modeling decisions that lead to setting the Risk Premium at the expected loss level, and aligning the models with a general consensus across the actuarial community, including setting the Risk Premium at a one standard deviation loss.</td>
</tr>
<tr>
<td><strong>Applicability of Moody’s Rated Corporate Data to Other Asset Classes</strong></td>
<td>C1 RBC base factors were developed using Moody’s default rate data on Moody’s rated public corporate bonds (this report, as well as references herein, uses public corporate and Moody’s rated corporate interchangeably) supplemented with S&amp;P’s recovery data. After controlling for ratings, we find material differences in observed default, migration, and recovery dynamics across asset classes. These differences question the effectiveness of using public corporate bond data for all asset classes. Moody’s Analytics recommends evaluating the possibility of estimating distinct C1 factors using asset-class specific data. For private placements, in particular, Moody’s recommends exploring a centralized collection of default, migration, and recovery data that can later be used in further estimating distinct C1 factors and for other purposes.</td>
</tr>
<tr>
<td><strong>Simulation and Correlation</strong></td>
<td>The current C1 factor model does not account for variation in cross-industry and cross-asset class concentration risks nor diversification that may be different across life companies’ portfolios. These variations can be material, and we recommend additional analysis that assesses the materiality of abstracting from cross-industry and cross-asset class differentiation.</td>
</tr>
</tbody>
</table>
Maturity Effect on Capital Factors

The C1 factors do not differentiate risk across maturity. This can create a material distorted incentive to hold longer-dated bonds whose credit risk is more sensitive to the credit environment. Moody’s recommends exploring a maturity adjustment to the C1 factors.

Investment Income Offsets

While investment income can be used to offset loss and support statutory surplus, the C1 factors are modeled with the implicit assumption that all investment profits are fully distributed to policyholders or used to absorb product or operational losses. This introduces a potential bias in differentiating investment income across assets, across rating categories, and across asset classes. Accounting for such heterogeneity in investment income can potentially lead to substantial differences in RBC factors across ratings and asset classes. Moody’s recommends more accurately differentiating investment income across assets in the C1 factors.

Comparability Across NRSROs

The model is developed using Moody’s rating only. However, NAIC rating designations are often determined by a set of NRSROs ratings. NRSROs have unique differences in credit rating methodologies and do not provide correspondence because they base their credit ratings on a range of qualitative, as well as quantitative, factors. This creates a challenge when mapping ratings across NRSROs to the various NAIC rating designations. It is plausible that the properties (such as default rate, recovery, etc.) of the NAIC rating in practice are substantially different from those of Moody’s rating used in the model development. With this in mind, we recommend an assessment of variation across NRSROs rating migration, default, and recovery rates, and across the credit cycle. If this is not possible because of, say, lack of historical data, Moody’s Analytics recommends revisiting the use of the second-lowest NRSROs rating in assigning the NAIC designation.

Climate Hazards and Emerging Risks

The C1 factors do not explicitly consider climate hazards or emerging risks (e.g., pandemic or cyber). These risks may not be explicitly incorporated into NRSRO ratings and may not be reflected in the historical data used in estimating the C1 factors. While climate hazards are particularly relevant for the likes of real estate and municipal credit, growing evidence suggests climate hazards and other emerging risks can be material for corporate credit. Moody’s Analytics recommends exploring the potential impact of climate hazards and emerging risks on C1 factors across asset classes.

The remainder of this report is organized as follows:

» Section 2 provides Moody’s Analytics’ general understanding of the C1 factor proposed model.
» Section 3 reviews the key model inputs.
» Section 4 reviews the different model components.
» Section 5 reviews model elements outside the Defined Scope.
» Section 6 concludes and suggests next steps.

It is important to note that Moody’s Analytics does not have access to the C1 Factor Proposal’s model, data, or final comprehensive technical documentation. Moreover, there have been multiple revisions to the proposed C1 factors. Moody’s Analytics has obtained the ACLI model rebuild, which closely replicates the published C1 factors. This rebuild does not include key elements such as the portfolio concentration adjustment or the model that assigns RMBS/CMBS NAIC ratings. While structured asset rating designations are out of scope in this report, we do opine on the effectiveness of corporate factor use. The ACLI’s replicated model and the C1 Factor Proposal’s methodology papers, along with written communications between the two institutions, were used to review and assess the modeling approach and assumptions. The recommendations and proposals that follow are based on Moody’s Analytics’ best understanding of the current proposal.
2 General Description of the C1 RBC Proposed Model

The NAIC establishes RBC formulas used to identify potentially weakly capitalized insurance companies. RBC establishes a de facto minimum amount of capital to be held by insurers in order to avoid regulatory intervention. This minimum capital amount protects statutory surplus from the fluctuations that reduce statutory surplus, including credit risk, deferral risk, subordination risk, and event risk.6

C1 capital provides protection from statutory insolvency due to losses in statutory asset value resulting from bond defaults, common stock depreciation, and other changes associated with investment activity flowing through statutory surplus.

The prevailing C1 factors were implemented and reported in 1994 with reference to 1970–1990 default experiences. The C1 Factor Proposal was revised multiple times during the 2015–2019 period in response to stakeholder feedback. While the proposed C1 factors were developed based on the loss experience of public U.S. corporate bonds, the same set of factors were recommended for all fixed income securities in NAIC’s Schedule D, which is used to report long-term bonds and stocks owned, acquired, sold, redeemed, or otherwise disposed of by insurers during a year. RMBS/CMBS securities are generally filed to NAIC Securities Valuation Office (SVO) and assigned NAIC designations through a financial modeling process conducted by the NAIC Structured Securities Group (SSG), subject to limited filing exemptions (NAIC Securities Valuation Office and NAIC Structured Securities Group, 2019). C1 factors are applied to RMBS/CMBS securities based on the NAIC designations. Based on discussions with the ACLI, other structured securities are treated identically as bonds and are not required to go through the NAIC designation process.

C1 capital charges are intended to cover the 96th percentile portfolio loss in excess of those anticipated in the statutory reserve over a 10-year horizon. Statutory reserve is reflected in the capital fund as Risk Premium, which is currently modeled as the level of annual mean loss from default (after tax and considering recoverable tax on default loss) derived from baseline default and recovery rate assumptions. Risk Premiums are assumed to earn 5% pre-tax interest per annum.

Key inputs to the framework are as follows:

1. Baseline default rates are estimated using 1983–2012 default data, sourced from Moody’s (Moody’s Investors Service, 2013) as referenced in (American Academy of Actuaries, 2015). For each rating, the marginal default rates in Years 1 through 10 are smoothed using a 4th degree polynomial regression to remove noise. Default rates are differentiated across economic states (e.g., expansion or contraction) using a set of estimated scalars.

2. Baseline recovery rates are estimated using recovery data of senior unsecured bonds provided by Standard & Poor’s, covering 1987–2012.

3. Representative portfolios for the seven size categories are constructed based on the corporate bond holdings of life insurers provided by NAIC to the Academy. The final representative portfolio size is set as $10−25 billion USD. Issuers’ holding amounts are estimated from a sample of actual life insurers’ portfolios (see Section 3.4 for details). Note, only the holding amounts of NAIC-1 and NAIC-2 issuers (824 total) in this portfolio are used to determine the holding amount for each bond in the portfolio, for every rating category in the simulation model. In other words, the representative portfolio for each rating category only differs by issuer rating.

With key inputs in hand, the C1 factor for each rating category is calculated separately through simulation methods. It represents the amount of initial funds needed to cover the 96th percentile greatest default loss over 10 years, offset by statutory reserve, proxied through each rating’s Risk Premium. The modeling framework relies on the following calculation steps:

1. Simulate annual economic state for 10 years.

2. The default rate for each rating category in each year is determined by applying a leveled economic state scalar to the baseline default rate, adjusting it up or down according to the simulated economic state.

3. Based on the simulated economic state, simulate a random loss given default (LGD) value for each year, from one of the two distributions (from Step 1) corresponding to the economic state.

4. Simulate representative portfolio loss in each year for each rating category based on the default rate, recovery rate, and the assumptions on Risk Premium and tax, etc. Determine the maximum cumulative portfolio loss with consideration of recoverable tax on default loss in the 10-year period.

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5. Set the base C1 factor for each rating category as the initial fund required on top of Risk Premium to cover the maximum loss at 96th percentile safety level. The values of these factors in the latest proposal are presented in the last column of Table 4.

6. Double the C1 factor of the ten largest issuers held across all debt-related asset classes. The initial filter excludes bonds with C1 RBC equal to zero and NAIC-1 bonds. As applicable after the first filter, if a top-ten issuer has NAIC-1 bonds, they are added back. Up to ten bond issuers of a bond portfolio can be subject to the top-ten doubling rule for concentration risk.

7. Apply the base C1 factors on 677 actual life-insurer portfolios to examine the expected capital coverage for a portfolio with different sizes and to determine the corresponding portfolio adjustment factor that results in enough capital for the portfolio at the 96th percentile safety level. Table 5 presents the final proposed adjustment factors.

### Table 4: Base C1 Factor8

<table>
<thead>
<tr>
<th>Current</th>
<th>August 2015</th>
<th>June 2017</th>
<th>Sept 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aaa</td>
<td>0.40%</td>
<td>0.28%</td>
<td>0.22%</td>
</tr>
<tr>
<td>Aa1</td>
<td>0.40%</td>
<td>0.43%</td>
<td>0.32%</td>
</tr>
<tr>
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<td>0.63%</td>
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</tr>
<tr>
<td>Aa3</td>
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<td>0.79%</td>
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</tr>
<tr>
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<td>0.98%</td>
</tr>
<tr>
<td>Baa1</td>
<td>1.30%</td>
<td>1.49%</td>
<td>1.13%</td>
</tr>
<tr>
<td>Baa2</td>
<td>1.30%</td>
<td>1.68%</td>
<td>1.32%</td>
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<td>1.57%</td>
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<td>Ba1</td>
<td>4.60%</td>
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<td>B2</td>
<td>10.00%</td>
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<td>Caal</td>
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<td>Caal2</td>
<td>23.00%</td>
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<td>Caal3</td>
<td>23.00%</td>
<td>29.82%</td>
<td>29.06%</td>
</tr>
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</table>

Source: (American Academy of Actuaries, 2017)

### Table 5: Portfolio Adjustment Factor

<table>
<thead>
<tr>
<th>Current PA Formula</th>
<th>Recommended PA Formula (September 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issuers Factor</td>
<td>Issuers Factor</td>
</tr>
<tr>
<td>Up to 50</td>
<td>Up to 10</td>
</tr>
<tr>
<td>2.59</td>
<td>7.80</td>
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<tr>
<td>Next 50</td>
<td>Next 90</td>
</tr>
<tr>
<td>1.30</td>
<td>1.75</td>
</tr>
<tr>
<td>Next 300</td>
<td>Next 100</td>
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<tr>
<td>1.00</td>
<td>1.00</td>
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<tr>
<td>Over 400</td>
<td>Over 500</td>
</tr>
<tr>
<td>0.90</td>
<td>0.75</td>
</tr>
</tbody>
</table>

Source: (American Academy of Actuaries, 2017)

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1. Note, the target percentile for base RBC factors for individual exposure before portfolio adjustment factor has been updated from the 92nd to the 96th percentile. See correspondence by American Academy of Actuaries (2017) for details.
2. The factor for Caal3 should be capped at the 30% factor for unaffiliated common stock. Under the current RBC scheme, the factor for NAIC 6 bonds in or near default is set equal to the base factor for unaffiliated common stock (American Academy of Actuaries, 2017).
The following sections examine the various input and methodology steps, exploring the underlying assumptions, potential biases, and materiality, along with recommendations. Section 3 focuses on key inputs. Section 4 explores the modeling framework.

3 Key Inputs to the Framework

This section reviews the key inputs used in the C1 RBC proposed model. We explore the underlying data, along with the assumptions and methodologies, potential biases, and materiality, along with recommendations. This section is organized as follows: Section 3.1 explores the baseline default rates, Section 3.2 explores LGD, Section 3.3 explores the discount rate, Section 3.4 explores the construction of the representative portfolio, and Section 3.5 explores the tax assumptions.

3.1 Default Rates

This section explores the cohort methodology and data used in estimating baseline default rates, as well as the path-dependent behavior of ratings and associated default rates.9

3.1.1 Summary of Moody’s Analytics Significant Areas of Review and Recommendations

The methodologies used in the C1 Factor Proposal to construct default rates across ratings, as well as methodologies used in differentiating default rates across expansion and contraction states, face data limitation challenges. Moody’s recommends updating the methodologies and using additional data referenced in the review that have been demonstrated to better capture credit dynamics.

3.1.2 Review and Analysis Performed by Moody’s Analytics

The C1 Factor Proposal takes a cohort approach, whereby all bonds of a given rating, as of a given start date, are kept track of over time. For example, all A2-rated bonds on January 1, 1995 make up a cohort. Experience for each cohort is measured over the following calendar years without considering any rating change subsequent to the cohort start date.

For each rating, the C1 Factor Proposal smoothed the recommended default rate using a 4th degree polynomial regression to remove noise as presented in Table 6. The C1 Factor Proposal noted, “In analyzing the raw Moody’s cohort data, issues with data credibility were observed in cells with scarce data. Therefore, a smoothing technique was applied to create smooth probability of default curves across ratings and experience years.”

Table 6: Smoothed (Across Ratings) Spot Default Rates-4th Degree, based on 2012 Moody’s Study

<table>
<thead>
<tr>
<th>Rating</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6</th>
<th>Year 7</th>
<th>Year 8</th>
<th>Year 9</th>
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<tbody>
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<td>0.0331%</td>
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</tr>
<tr>
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<td>0.0081%</td>
<td>0.1066%</td>
<td>0.0694%</td>
<td>0.0575%</td>
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<td>0.0459%</td>
<td>0.0459%</td>
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<td>Aa2</td>
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<td>0.0334%</td>
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<td>0.132%</td>
<td>0.0883%</td>
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<td>Aa3</td>
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<td>0.0401%</td>
<td>0.0853%</td>
<td>0.2503%</td>
<td>0.1628%</td>
<td>0.1277%</td>
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<td>0.3348%</td>
<td>0.3761%</td>
<td>0.3744%</td>
<td>0.4137%</td>
</tr>
<tr>
<td>Ba1</td>
<td>0.1463%</td>
<td>0.2813%</td>
<td>0.3777%</td>
<td>0.3050%</td>
<td>0.4200%</td>
<td>0.4516%</td>
<td>0.4613%</td>
<td>0.4853%</td>
<td>0.4750%</td>
<td>0.5199%</td>
</tr>
<tr>
<td>Ba2</td>
<td>0.2115%</td>
<td>0.4094%</td>
<td>0.4078%</td>
<td>0.3258%</td>
<td>0.5357%</td>
<td>0.5994%</td>
<td>0.6233%</td>
<td>0.6139%</td>
<td>0.5906%</td>
<td>0.6172%</td>
</tr>
<tr>
<td>Ba3</td>
<td>0.2980%</td>
<td>0.5802%</td>
<td>0.4224%</td>
<td>0.3876%</td>
<td>0.6810%</td>
<td>0.7939%</td>
<td>0.8316%</td>
<td>0.7749%</td>
<td>0.7352%</td>
<td>0.7424%</td>
</tr>
</tbody>
</table>

Source: (American Academy of Actuaries, 2015)

Two aspects of the approach warrant further exploration. First, the fundamental limitations of the data, as it relates to the framework, i.e., statistical properties of the data (e.g., path-dependent behavior) and the number of observations per rating category. Second, the use of the cohort approach.

We begin with an observation (Moody’s Investors Service, 2020 (1)): Moody’s credit ratings are opinions of ordinal, horizon-free credit risk and, as such, do not target specific default rates or expected loss rates. Moody’s believes the needs of market

9 The term “path-dependent,” recognizes the history of a bond’s rating as well as its current rating affects the bond’s future rating state and migration. For example, a bond that has experienced a recent rating action may be less likely to experience an additional rating action in the immediate future, when compared to an otherwise identical bond. An equivalent term, non-Markovian, is often also used in references herein.
participants are best served by ratings that are assessments of relative credit risk rather than cardinal risk measures. Indeed, rating transitions are path-dependent. By the same logic, neither are migrations implicit in the cohort default rates term structures. Thus, one should recognize that using ratings data in this way does not consider potentially material time-series dynamics.

While the use of a cohort approach is legitimate in principle, limitations must be understood. Limitations cited by authors of the C1 Factor Proposal with the number of observations per rating category and noted challenges with subsets of data, such as the change in ratings methodology in the financial sector after the financial crisis in 2008–2009, are well recognized (Moody’s Investors Service, 2020 (1)). While the C1 Factor Proposal recommends the smoothing method that best fits the original data, it is not clear if this chosen performance criteria makes sense in light of the data limitations (i.e., statistical properties and number of observations). Fitting a smoothing function on noisy data can often lead to a poor description of reality. This issue is exacerbated by poor statistical properties, including the path-dependent nature of default rates.

The C1 Factor Proposal recognizes this point when considering combining transition tables with default rates while incorporating credit migration. However, they also cited the observed and legitimate challenge that the progression of ratings transition for a bond is path-dependent. This challenge is prevalent in the cohort approach as well. We return to path-dependency related issues later in this section.

While challenges abound, we transition to an alternative point of reference. Moody’s Idealized Default Rates, presented in Table 7, provide a benchmark for default rates across ratings. This was independently suggested by ACLI technical experts based on interviews.10

### Table 7: Moody’s idealized annual spot expected default rates used as benchmark default probability rates in Moody’s rating models

<table>
<thead>
<tr>
<th>Rating</th>
<th>1-Year</th>
<th>2-Year</th>
<th>3-Year</th>
<th>4-Year</th>
<th>5-Year</th>
<th>6-Year</th>
<th>7-Year</th>
<th>8-Year</th>
<th>9-Year</th>
<th>10-Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aaa</td>
<td>0.0001%</td>
<td>0.0001%</td>
<td>0.0005%</td>
<td>0.0011%</td>
<td>0.0011%</td>
<td>0.0012%</td>
<td>0.0014%</td>
<td>0.0016%</td>
<td>0.0018%</td>
<td></td>
</tr>
<tr>
<td>Aa1</td>
<td>0.0006%</td>
<td>0.0024%</td>
<td>0.0070%</td>
<td>0.0110%</td>
<td>0.0110%</td>
<td>0.0120%</td>
<td>0.0130%</td>
<td>0.0150%</td>
<td>0.0180%</td>
<td></td>
</tr>
<tr>
<td>Aa2</td>
<td>0.0014%</td>
<td>0.0066%</td>
<td>0.0180%</td>
<td>0.0210%</td>
<td>0.0210%</td>
<td>0.0220%</td>
<td>0.0240%</td>
<td>0.0290%</td>
<td>0.0361%</td>
<td></td>
</tr>
<tr>
<td>Aa3</td>
<td>0.0030%</td>
<td>0.0160%</td>
<td>0.0400%</td>
<td>0.0420%</td>
<td>0.0410%</td>
<td>0.0441%</td>
<td>0.0451%</td>
<td>0.0552%</td>
<td>0.0732%</td>
<td></td>
</tr>
<tr>
<td>A1</td>
<td>0.0058%</td>
<td>0.0312%</td>
<td>0.0800%</td>
<td>0.0721%</td>
<td>0.0721%</td>
<td>0.0763%</td>
<td>0.0743%</td>
<td>0.0934%</td>
<td>0.1277%</td>
<td></td>
</tr>
<tr>
<td>A2</td>
<td>0.0109%</td>
<td>0.0591%</td>
<td>0.1521%</td>
<td>0.1233%</td>
<td>0.1224%</td>
<td>0.1165%</td>
<td>0.1277%</td>
<td>0.1199%</td>
<td>0.1543%</td>
<td>0.2202%</td>
</tr>
<tr>
<td>A3</td>
<td>0.0389%</td>
<td>0.1111%</td>
<td>0.2103%</td>
<td>0.1807%</td>
<td>0.1910%</td>
<td>0.1813%</td>
<td>0.2018%</td>
<td>0.1921%</td>
<td>0.2229%</td>
<td>0.2843%</td>
</tr>
<tr>
<td>Baa1</td>
<td>0.0900%</td>
<td>0.1902%</td>
<td>0.2808%</td>
<td>0.2715%</td>
<td>0.2723%</td>
<td>0.2730%</td>
<td>0.3042%</td>
<td>0.3051%</td>
<td>0.3060%</td>
<td>0.3377%</td>
</tr>
<tr>
<td>Baa2</td>
<td>0.1700%</td>
<td>0.3005%</td>
<td>0.3617%</td>
<td>0.3731%</td>
<td>0.3846%</td>
<td>0.3963%</td>
<td>0.4488%</td>
<td>0.4509%</td>
<td>0.4014%</td>
<td>0.3721%</td>
</tr>
<tr>
<td>Baa3</td>
<td>0.4200%</td>
<td>0.6327%</td>
<td>0.6670%</td>
<td>0.6817%</td>
<td>0.6863%</td>
<td>0.6704%</td>
<td>0.6542%</td>
<td>0.6690%</td>
<td>0.6314%</td>
<td>0.5613%</td>
</tr>
<tr>
<td>Ba1</td>
<td>0.8700%</td>
<td>1.1601%</td>
<td>1.1329%</td>
<td>1.1046%</td>
<td>1.1273%</td>
<td>1.0241%</td>
<td>0.8640%</td>
<td>0.8930%</td>
<td>0.8685%</td>
<td>0.7776%</td>
</tr>
<tr>
<td>Ba2</td>
<td>1.5600%</td>
<td>1.9403%</td>
<td>1.7715%</td>
<td>1.7085%</td>
<td>1.7275%</td>
<td>1.4849%</td>
<td>1.0307%</td>
<td>1.0750%</td>
<td>1.1207%</td>
<td>0.9731%</td>
</tr>
<tr>
<td>Ba3</td>
<td>2.8100%</td>
<td>2.7781%</td>
<td>2.4976%</td>
<td>2.0840%</td>
<td>2.2946%</td>
<td>1.8493%</td>
<td>1.3062%</td>
<td>1.2766%</td>
<td>1.1864%</td>
<td>1.1406%</td>
</tr>
<tr>
<td>B1</td>
<td>4.6800%</td>
<td>3.8817%</td>
<td>3.4927%</td>
<td>2.5673%</td>
<td>2.6349%</td>
<td>2.1102%</td>
<td>1.5102%</td>
<td>1.3602%</td>
<td>1.2661%</td>
<td>1.2189%</td>
</tr>
<tr>
<td>B2</td>
<td>7.1600%</td>
<td>4.8578%</td>
<td>4.3926%</td>
<td>3.0551%</td>
<td>3.1513%</td>
<td>2.4467%</td>
<td>1.7582%</td>
<td>1.5002%</td>
<td>1.4295%</td>
<td>1.3283%</td>
</tr>
<tr>
<td>B3</td>
<td>11.6200%</td>
<td>5.6461%</td>
<td>5.3004%</td>
<td>3.8116%</td>
<td>3.9626%</td>
<td>2.9472%</td>
<td>2.5424%</td>
<td>2.2899%</td>
<td>1.7799%</td>
<td>1.6913%</td>
</tr>
</tbody>
</table>

Before proceeding, it is important to understand the purpose and use of Moody’s Idealized Default Rates that have remained unchanged since 1989. Per the most recent Rating Symbols and Definition (Moody’s Investors Service, 2020 (1)):

To rate some obligations in some asset classes, however, Moody’s uses models and tools that require ratings to be associated with cardinal default rates, expected loss rates, and internal rates of return in order for those models and tools to generate outputs that can be considered in the rating process. For these purposes, Moody’s has established a fixed common set of default rates, expected loss rates, and internal rates of return that vary by rating category and/or investment horizon (Moody’s Idealized

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10 The question of applicability of the corporate data for other asset classes is discussed in Section 5.1.
Default and Expected Loss Rates, hereafter called “Moody’s idealized rates”). By using a common fixed set of benchmark parameters, rating models are more likely to provide consistency with respect to the estimation of relative risk across rating levels and investment horizons and can be more easily compared to one another. Moody’s idealized rates are used with other tools and assumptions that have a combined effect on model outcomes. While cardinal measures are used as inputs to models, the performance of ratings is benchmarked against other metrics. Although Moody’s idealized rates bore some degree of relationship to corporate default and loss experience at the time they were created, that relationship has varied over time, and Moody’s continuing use of the idealized rates for modeling purposes does not depend on the strength of that relationship over any particular time horizon. When we perceive changes in risk that necessitate changes in our credit analysis, we make revisions to key assumptions and other aspects of models and tools rather than changing this fixed common set of benchmark parameters. This approach enables us to make adjustments that only affect the particular sectors and asset classes we expect will experience significant changes in risk at a given time.

A casual comparison across the two-term structures highlights important differences. For example, monotonically increasing spot rates for the high-grade universe is commonly recognized as high-quality credit that is more likely to deteriorate than improve; this condition is not met with the recommended baseline term structure. With this, we do recognize that the idealized default rates are not intended to match historical or future ratings performance.

Next, we consider modeling default rates across contraction and expansion economic states, closely related to path-dependency issues with the data. We apply a distinct, single multiplier to each rating baseline default rate. While, in spirit, the approach makes sense, practicalities do not lend themselves in describing the tendencies for the default rate term structure to tilt and become upward (or less downward) sloping during a benign environment and more downward (or less upward sloping) during a deteriorated environment (Beygi, Makarov, Zhao, & Dwyer, 2016). Section 4.1 further discusses the challenges associated with the economic state framework.

With these factors in mind, material improvements in techniques and data availability have been made, allowing more accurate capturing of nuanced time series dynamics for rating migration and default across credit environments that address the observed path-dependent behavior of ratings. These approaches are used in practice by a wide range of institutions, as documented in a number of methodology papers by Moody’s (Moody’s Analytics, 2020) and others, such as (Lando & Skadedberg, 2002) and (Aguais, Forest, & Wong). Moody’s Analytics recommends exploring these approaches. Section 4.1 further discusses the economic state model.

### 3.2 Recovery Rates

#### 3.2.1 Summary of Moody’s Analytics Significant Areas of Review and Recommendations

The method used by the C1 Factor Proposal to recognize the recovery date does not align with the date of default. This deviation can result in bias with recovery rate levels, as well as their relationships with default rates. Moody’s Analytics recommends exploring the use of more accurate data and groups when describing LGD distributions and utilizing more current techniques that link recovery with the credit environment.

#### 3.2.2 Review and Analysis Performed by Moody’s Analytics

The C1 Factor Proposal estimates two empirical distributions of LGD, for economic contraction and expansion, respectively, using historical data. Each LGD distribution consists of 11 buckets, <0, 0-10%, 10-20%, etc., each with an average LGD and probability of occurrence. Negative LGD corresponds to recovery greater than par value (American Academy of Actuaries, 2015). For example, to construct the LGD distribution for a contraction state, the bond-level LGD data in the contraction period 1983–2012 are grouped into the aforementioned 11 buckets first. Then, the relative frequencies of LGD data points are used as the probability of

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11 These tables are highly stylized and are not intended to match historical or future ratings performance. The tables were constructed in 1989 with reference to corporate default and loss experience over four historical data points. In particular, the 10-year idealized default rates for A2, Baa2, Ba2, and B2 were set equal to the 10-year historical default rates for corporate issuers with single A, Baa, Ba, and single B ratings, as observed between 1970 and 1989. In contrast, the 10-year idealized default rates for Aa3 and Aa2 were set lower than their historical default rates. All the other idealized default rates— for different alphabetic ratings and at different rating horizons—were derived through interpolation, rather than being matched to historical data. The idealized expected loss table was then derived by multiplying each element of the idealized default table by an average loss severity assumption, set equal to the approximate historical recovery rate of senior unsecured debt observed between 1970 and 1989. Moody’s has not published a revised version of these tables since the 1989 version and has no plans to revise them at the time of this writing.

12 Moody’s approach to measuring ratings performance is discussed in “Measuring the Performance of Credit Ratings” (Moody’s Special Comment, November 2011).
each bucket. For each simulation trial, the proposed model randomly chooses an LGD bucket using the probability of occurrence for each bucket, and then uses the average LGD of the selected bucket to compute loss.

Data used to develop the LGD distribution is based on senior unsecured bond data provided by Standard & Poor’s, covering 1987–2012. The average LGD is 53.1% among 1,260 bonds. The detailed LGD data collected from S&P has not been disclosed to either ACLI or Moody’s Analytics. ACLI attempted to re-construct the LGD distributions using Moody’s recovery data and managed to obtain similar, average LGD (53.1%) and sample size (1,257 bonds). Furthermore, the LGD distributions replicated by ACLI were used in the portfolio loss simulation and resulted in nearly-identical RBC factors for all ratings except Caa3. Therefore, we use ACLI’s replication methods for evaluation.

We make three observations regarding the data and the methods by which the data are used to parameterize the economic state model.

First, the C1 Factor Proposal used bond-level recovery data to estimate the empirical LGD distribution. The C1 Factor Proposal recognized that “recovery rates are provided by the issuer, not by issue” but argued that “because the LGD by issuer rating are stable, it is reasonable to assume that the variability in recovery would be observed at the issue level” (American Academy of Actuaries, 2015). Based on empirical observations, this data may be influenced by issuers with a large number of bond defaults. The underlying risk factors are largely the same for bonds linked to the same issuers. For example, 49 senior unsecured bonds from Pacific Gas & Electric (PG&E) defaulted, all with zero LGD in 2001, one of the four contraction years. The estimated LGD distribution for economic contraction will, therefore, be influenced heavily by PG&E bond defaults. We can address this issue using principal-weighted LGD by issuers first and then using the average of issuer LGDs.

Second, Moody’s Analytics’ recovery data provides up to three alternative methods for deriving LGD, depending on data availability. For each defaulted bond, the LGDs from the three methods can differ. Moody’s Ultimate Recovery Database includes a field with Moody’s recommended method for each default, based on Moody’s extensive experience with recovery data (Moody’s Analytics, 2016). While the C1 Factor Proposal used LGD data provided by S&P, it does not clearly define from which method(s) LGD is derived:

- Settlement Method — value of the settlement instruments is taken at or close to default
- Liquidity Method — value of the settlement instruments is taken at the time of a liquidity event
- Trading Price Method — value of the settlement instruments is based on the trading prices of the defaulted instruments at post-emergence

Third, based on the electronic communications between ACLI and the Academy, recovery rate seems to have been categorized by the date of emergence from default rather than the default date (American Council of Life Insurers, 2019). It is not uncommon for the recovery process to take years to complete. The year of emergence is likely to be in a different economic state from the year of default. As a result, the empirical LGD distribution for a contraction economic state may be estimated from defaults that occurred primarily during expansion years. This process is contradictory to the loss simulation model in the C1 Factor Proposal, where loss is realized on the year of default.

With these issues in mind, Moody’s Analytics recommends using issuer-level LGD data derived from the more commonly used recovery method and grouped by the year of default to estimate the empirical LGD distributions. More broadly, there have been advances in techniques that allow more accurately linking recovery with the credit environment ((Moody’s Analytics, 2011), (Moody’s Analytics, 2010 (2)), and that account for correlation between the firm’s underlying credit quality and recovery, used in practice that should be considered when modeling LGD dynamics.

3.3 Discount Rate

3.3.1 Summary of Moody’s Analytics Significant Areas of Review and Recommendations

Since the modeling work was conducted by Academy in 2015, the discount rate used in the model is calculated using historic data that does not reflect the current low-interest environment, nor the expected continuation of a low interest rate environment. Moody’s Analytics recommends updating the discount rate to include December 31, 2013 to December 31, 2020 data to better reflect the current and expected interest rate environment in conjunction with updated tax assumptions that reflect the 2017 Tax Act (see Section 3.5 for details).
3.3.2 Review and Analysis Performed by Moody’s Analytics

This section evaluates data and methods used in estimating the discount rate. The discount rate used in the C1 Factor Proposal is assumed to be the average ten-year LIBOR swap rate from December 31, 1993 to December 31, 2013, which is 5.02% pre-tax/3.26% after-tax. The numbers are then rounded to 5% pre-tax/3.25% after-tax (American Academy of Actuaries, 2015). If the discount rate is updated through April 30, 2017, the pre-tax rate drops to 4.2%, as documented in the Academy’s letter on February 14, 2018 (American Academy of Actuaries, 2018). It is recognized that this time window for the discount rate is chosen since the modeling work was conducted in 2015.

While Moody’s Analytics does not have access to the data used in the C1 Factor Proposal, or information about the exact data source, we use the 10-year USD swap rate from the Federal Reserve H.15 Daily Selected Interest Rates Release and Intercontinental Exchange (ICE) in our analysis. ICE data was used starting August 1, 2014, when the Federal Reserve System data series was discontinued.

Figure 1 shows the downward trend in the 10-year USD swap rate over the most recent two decades. The rate is below 3% for most of the 2011−2021 period. Since the Federal Reserve took extensive measures to support the economy during the global pandemic (Federal Reserve, 2020), the rate decreased further, often to under 1%. The November Minutes of the Federal Open Market Committee quotes, "The Committee decided to keep the target range for the federal funds rate at 0−¼% and expects it will be appropriate to maintain this target range until labor market conditions have reached levels consistent with the Committee's assessments of maximum employment and inflation has risen to 2% and is on track to moderately exceed 2% for some time" (the Federal Open Market Committee, 2020). Therefore, it is reasonable to assume that the current low interest rate environment will likely remain for an extended period, considering the 30-year treasury rate sat under 2% at the time we wrote this report.

With these observations in mind, Moody’s Analytics recommends updating the discount rate to include December 31, 2013 to December 31, 2020 data to better reflect the current and expected interest rate environment. Please note, the 2017 Tax Act took effect during this time window. Section 3.5 discusses the update to tax assumptions.

Figure 1: 10-Year USD Swap Rate

Source: Federal Reserve System (data prior to August 1, 2014) and Intercontinental Exchange (data on or after August 1, 2014).
3.4 Construction of the Representative Portfolio

3.4.1 Summary of Moody’s Analytics Significant Areas of Review and Recommendations

The segmentation and filtering of the sample portfolios used to construct the representative portfolio are not accompanied by economic justification or sensitivity analysis. For example, for reasons not explained, only NAIC1 and NAIC2 rated issuers are used to determine the number of bonds in the representative portfolio for all rating categories. In addition, each representative portfolio ultimately used in the simulation contains one rating category, which makes the final C1 factors heavily dependent on portfolio adjustment factors. Given the importance of the representative portfolio, we recommend more comprehensive documentation and robustness tests that can show whether the segmentation and filtering method has material impact on the C1 factors and explore the option of constructing a representative portfolio that contains all rating categories.

3.4.2 Review and Analysis Performed by Moody’s Analytics

Base C1 factors are intended to cover 96th percentile portfolio loss in excess of those anticipated in the statutory reserve over a 10-year horizon. The C1 factors are estimated using simulation methods described in Section 5.2. This section describes the representative portfolio analyzed in the simulation.

The representative portfolio for each rating category consists of bonds with the same initial rating. The number of bonds, as well as the holding amount of each bond in the portfolio, is determined according to the corporate bond holdings as of December 31, 2011, of the entire universe of 782 life insurers (portfolio size range from under $0.5 billion to $80 billion) provided by NAIC to the authors of the C1 Factor Proposal; Moody’s Analytics did not have access to these portfolios. In total, seven representative portfolios are created from life insurers in different size categories; only the portfolio created based on 24 insurers with portfolio size between $10−$25 billion is used in the end.

The C1 Factor Proposal constructs the reference portfolio by placing each credit portfolio into seven size categories, shown in Table 8. Under the argument that Category 6 contains the 50% cumulative Book Adjusted Carrying Value (BACV) point with a range of 33%−56% of industry BACV, the C1 Factor Proposal chose the 24 life companies’ portfolios in this category to form the basis of the representative portfolio.

Table 8: Life Company Size Categories

<table>
<thead>
<tr>
<th>Size</th>
<th>$Billion</th>
<th>$Billion</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.0</td>
<td>0.5</td>
<td>503</td>
</tr>
<tr>
<td>2</td>
<td>0.5</td>
<td>1.0</td>
<td>54</td>
</tr>
<tr>
<td>3</td>
<td>1.0</td>
<td>2.5</td>
<td>70</td>
</tr>
<tr>
<td>4</td>
<td>2.5</td>
<td>5.0</td>
<td>35</td>
</tr>
<tr>
<td>5</td>
<td>5.0</td>
<td>10.0</td>
<td>32</td>
</tr>
<tr>
<td>6</td>
<td>10.0</td>
<td>25.0</td>
<td>24</td>
</tr>
<tr>
<td>7</td>
<td>25.0</td>
<td>80.0</td>
<td>16</td>
</tr>
</tbody>
</table>

Bonds from these 24 portfolios are then ranked by BACV and segmented into 18 groups. Group 1, 2, 17, and 18 each hold 1/32 of the total BACV, while the remaining 14 groups hold 1/16 of BACV. In the final representative portfolio, the initial holding amount of bonds in each group is set to be the average BACV of the corresponding group from the 24 life insurer’s portfolio (last column of Table 9). The number of bonds in each group, on the other hand, is set to be the average (across 24 insurer’s bond portfolios) number of issuers in each group with rating NAIC-1 or NAIC-2. This results in a final representative portfolio with a total of 824 bonds across 18 groups, with each group’s total holding amount determined by the last column of Table 9.

---

13 Bonds guaranteed by the full faith and credit (FFC) of the U.S. government, affiliate bonds and zero value bonds are removed from the sample.

14 In total, seven representative portfolios are created from life insurers in different size categories; only the portfolio created based on 24 insurers with portfolio size between $10−$25 billion is used in the end.
Table 9: Representative Portfolio

<table>
<thead>
<tr>
<th>Bin</th>
<th>NAIC Rating</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>$Million</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>82</td>
<td>76</td>
<td>47</td>
<td>35</td>
<td>8</td>
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<tr>
<td>2</td>
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<td>36</td>
<td>15</td>
<td>10</td>
<td>1</td>
<td>5.062</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>56</td>
<td>53</td>
<td>13</td>
<td>6</td>
<td>2</td>
<td>7.789</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>39</td>
<td>42</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>11.108</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>30</td>
<td>34</td>
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<tr>
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<td>8</td>
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</tr>
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<td>9</td>
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<tr>
<td>13</td>
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<td>0</td>
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<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>55.684</td>
</tr>
<tr>
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<td>7</td>
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<td>0</td>
<td>65.445</td>
</tr>
<tr>
<td>16</td>
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<td>0</td>
<td>0</td>
<td>81.004</td>
</tr>
<tr>
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<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>95.349</td>
</tr>
<tr>
<td>18</td>
<td></td>
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<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>142.017</td>
</tr>
<tr>
<td>Issuer Count</td>
<td></td>
<td>405</td>
<td>419</td>
<td>97</td>
<td>55</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Coefficient of Variation</td>
<td></td>
<td>1.13</td>
<td>1.00</td>
<td>1.02</td>
<td>0.83</td>
<td>0.77</td>
<td></td>
</tr>
<tr>
<td>Issuer Count %</td>
<td></td>
<td>41%</td>
<td>42%</td>
<td>10%</td>
<td>6%</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Amount %</td>
<td></td>
<td>47%</td>
<td>47%</td>
<td>4%</td>
<td>1%</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

While Moody’s Analytics understands the objectives and the need to construct a representative portfolio, given the spirit of the framework justifications for various modeling choices and implications were not included in the documents. A few that stand out:

1. It is not clear how the initial seven size categories used to segment life insurers are determined. Given that the definition of the size categories ultimately determines which life insurers’ portfolios are used to construct the representative portfolio, there may be a material impact on base C1 factors. It is unclear whether any robustness test was done to examine to what extent the definition of size categories affects the C1 factor.

2. Ultimately, only 24 out of 782 life companies’ portfolios are used to construct the representative portfolio. As recognized in the C1 factor Proposal, these 24 portfolios are much larger in size than the industry average. The implication is that the base C1 factors calculated based on the representative portfolio are only applicable to large life companies’ portfolios. For smaller insurers, the effectiveness of the C1 factors is almost entirely dependent on the model of portfolio adjustment factors, which lack model documentation and backtesting. Section 4.2 provides a detailed review of the portfolio adjustment factors.

3. It is not clear why the exercise used to count the number of issuers is limited to NAIC-1 and NAIC-2, given representative portfolios are ultimately assigned the same number of bonds across all rating categories. If we include the count of issuers with NAIC-3 and below ratings from the 24 insurers’ portfolios, the number of bonds in the final representative portfolio will increase accordingly, which will add diversification and lower the base C1 factor.

4. Each representative portfolio ultimately used in the simulation contains one rating category, which again makes the final C1 factors heavily dependent on portfolio adjustment factors, which we review in Section 4.2.

With these observations in mind, Moody’s Analytics recommends providing economic justification for and conducting robustness tests on the definition of life insurers’ size categories. Moody’s Analytics also recommends exploring a revision to the representative portfolio’s construction to include all ratings and possibly asset classes in a single representative portfolio.
3.5 Tax Assumptions

The U.S. corporate tax rate was lowered from 35% to 21%, in accordance with the 2017 Tax Reconciliation Act (Deloitte, 2018). Net capital gains included in the taxable income are subject to the 21% rule (CCH Group, 2019). While the model was developed based on historical data before the tax cut, the RBC factors, if adopted, will be applied to insurers, which will pay the updated tax rate. It will be worthy to consider updating the assumed 35% tax rate to 21%. Moody’s recommends analysis reflecting the current tax environment. 15

4 Modeling Framework

This section reviews the assumptions and methodologies that underpin the modeling framework. Section 4.1 reviews the economic state model, Section 4.2 explores portfolio adjustment factors, and Section 4.3 explores the Risk Premium.

4.1 Economic State Model

4.1.1 Summary of Moody’s Analytics Significant Areas of Review and Recommendations

We have three main concerns regarding the economic state model, which are closely related to the discussion in Section 3.1. First, the two-state model does not accurately capture persistency in default and recovery rates across the credit cycle. Second, the economic state of LGD appears to be mistakenly disconnected from that of the default rate for ratings Baa-Caa. Third, the scaling factor used in differentiating default rates across expansions and contractions appears to be overly punitive for the investment-grade segment compared with historical patterns. Moody’s recommends a more holistic review for the choice of a framework that can address broader sets of issues, including more precise differentiation across asset classes, as discussed in other sections.

4.1.2 Review and Analysis Performed by Moody’s Analytics

To differentiate default rate and recovery rate during economic booms and downturns, the C1 Factor Proposal defines economic states according to the National Bureau of Economic Research’s (NBER) economic state classifications across the 1983–2012 period. Years 1991, 2001, 2008, and 2009 are classified as “contraction” years, while the remaining years are classified as “expansion” years. The baseline default rate is scaled up or down using an economic scalar for the economic state.

There are two models in the simulation process, as summarized in Table 10:

- The two-state model is used for recovery rates, and Aaa-A default rates, with the economic state in years one through ten drawn independently according to the probability summarized in Table 12.
- The four-state model is used for Baa-Caa default rates. It includes continuing expansion and continuing contraction states in addition to expansion and contraction states. The economic state in the first year is drawn from the probability distribution shown in Table 13. The states in subsequent years are dependent on the previous year’s state and follow the transition probabilities summarized in Table 14.

LGD is drawn from two different distributions corresponding to expansion and contraction state, respectively. Section 3.2.2 describes details.

---

15 The 2017 Tax Act repeals the 3-year carryback, 15-year carryforward period for life insurance companies’ operations losses. The Act provides that all corporations (including life companies) may carry NOLs forward indefinitely, but limits utilization of NOLs to 80 percent of a given year’s taxable income with no loss carryback capacity (Deloitte, 2018).
### Table 10: Definition of Two-state and Four-state economic models

<table>
<thead>
<tr>
<th>Economic model type</th>
<th>Economic state</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contraction</td>
<td></td>
</tr>
<tr>
<td>4-state model</td>
<td>Continued Expansion</td>
<td>The previous year was an “Expansion” and the present year is also an “Expansion.”</td>
</tr>
<tr>
<td></td>
<td>Expansion</td>
<td>The previous year was a “Contraction” and the present year is an “Expansion.”</td>
</tr>
<tr>
<td></td>
<td>Contraction</td>
<td>The previous year was an “Expansion” and the present year is a “Contraction.”</td>
</tr>
<tr>
<td></td>
<td>Continued Contraction</td>
<td>The previous year was a “Contraction” and the present year is also a “Contraction.”</td>
</tr>
</tbody>
</table>

### Table 11: Economic models for default rate and recovery rate

<table>
<thead>
<tr>
<th>Variable</th>
<th>Rating</th>
<th>Economic model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Default rate</td>
<td>Aaa, Aa, A</td>
<td>2-state economic model</td>
</tr>
<tr>
<td></td>
<td>Baa, Ba, B, Caa, C</td>
<td>4-state economic model</td>
</tr>
<tr>
<td>Recovery rate</td>
<td>All ratings</td>
<td>2-state economic model</td>
</tr>
</tbody>
</table>

### Table 12: Two-state probability distribution

<table>
<thead>
<tr>
<th>Economic State</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expansion</td>
<td>86.67%</td>
</tr>
<tr>
<td>Contraction</td>
<td>13.33%</td>
</tr>
</tbody>
</table>

### Table 13: Four-state probability distribution for the first year

<table>
<thead>
<tr>
<th>Economic State</th>
<th>Probability in Year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing expansion</td>
<td>73.33%</td>
</tr>
<tr>
<td>Expansion</td>
<td>13.33%</td>
</tr>
<tr>
<td>Contraction</td>
<td>10%</td>
</tr>
<tr>
<td>Continuing contraction</td>
<td>3.33%</td>
</tr>
</tbody>
</table>

### Table 14: Economic state transition probability for the four-state model

<table>
<thead>
<tr>
<th>State/Probability</th>
<th>Expansion</th>
<th>Contraction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expansion</td>
<td>88.00%</td>
<td>12.00%</td>
</tr>
<tr>
<td>Contraction</td>
<td>80.00%</td>
<td>20.00%</td>
</tr>
</tbody>
</table>

There are several data treatment and modeling assumptions that may be introducing bias and should be understood. First, the economic state model does not seem to capture serial correlations in defaults. The two-state model assumes the independence of economic states across years. Since default rate is calculated as the baseline default rate multiplied by an economic scalar, default rate is also assumed implicitly to be independent across the years. This assumption does not align with empirical patterns. For example, Figure 2 demonstrates the persistence in global corporate default rates of years before and after a peak.
While the dependence of economic states across years is established in the four-state model, the model may not be adequately capturing the default rate autocorrelation. The business cycle and the credit cycle do not perfectly overlap. As seen in Figure 3, multiple peaks in the U.S. high-yield default rate occurred outside the recession periods (Altman & Kuehne, 2016). It takes time for corporate fundamentals to weaken and reach the default point during a downturn.

Second, the default rate and recoveries for some ratings are modeled using different economic state scenarios. For Baa1-Caa3, default rate is modeled in the four-state model, while LGD is modeled using a separate two-state model. The ACLI’s replicated model is used to simulate the economic scenarios and test this modeling choice. Even if the four-state scenarios are mapped to two-state (for example, map continuing expansion to expansion), 23% of trials have different values from the separate two-state scenarios for LGD modeling. As a result, the default rate may be scaled up by the contraction economic scalar, while LGD is drawn from the distribution for expansion in any simulation trial.

Third, economic scalars used to scale the default rate across states are not adjusted for the remaining time to maturity (Years 1–10), referenced as leveled economic scalars. This approach fails to account for the default rate term structure effect. Specifically, Table 15 (American Academy of Actuaries, 2015) reports the original economic scalars directly calculated from the empirical data. We can see that the values of these scalar vary significantly across tenors. However, due to data noises, the pattern of these scalars is not always intuitive. Consequently, the C1 Factor Proposal compresses these economic scalars across tenors into a single
scalar for each economic state and rating, shown in Table 16 (American Academy of Actuaries, 2015). Taking Baa rating, for example, the leveled economic scalar for the contraction state is around 215%. This percentage is lower than the empirical scalar in Years 9–10 and higher than the empirical scalar in Years 1–8.

The use of leveled economic scalars seems to be, in general, overly punitive for investment-grade issues in early years when the default rates tend to be lower, and not sufficiently punitive in later years when default rates tend to be higher. We expect this will dampen concentrated losses overall, but need to assess the dynamics, along with a review of the base default rate term structure.

Table 15: Economic scalar for Baa rating based on empirical data. Source: (American Academy of Actuaries, 2015)

<table>
<thead>
<tr>
<th>Duration 1</th>
<th>Duration 2</th>
<th>Duration 3</th>
<th>Duration 4</th>
<th>Duration 5</th>
<th>Duration 6</th>
<th>Duration 7</th>
<th>Duration 8</th>
<th>Duration 9</th>
<th>Duration 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued Contraction</td>
<td>463%</td>
<td>188%</td>
<td>253%</td>
<td>155%</td>
<td>255%</td>
<td>300%</td>
<td>334%</td>
<td>412%</td>
<td>445%</td>
</tr>
<tr>
<td>Contraction</td>
<td>120%</td>
<td>144%</td>
<td>162%</td>
<td>188%</td>
<td>189%</td>
<td>191%</td>
<td>209%</td>
<td>200%</td>
<td>248%</td>
</tr>
<tr>
<td>Expansion</td>
<td>126%</td>
<td>121%</td>
<td>96%</td>
<td>145%</td>
<td>140%</td>
<td>123%</td>
<td>112%</td>
<td>81%</td>
<td>64%</td>
</tr>
<tr>
<td>Continued expansion</td>
<td>68%</td>
<td>87%</td>
<td>86%</td>
<td>77%</td>
<td>73%</td>
<td>70%</td>
<td>73%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>Combined</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 16: Levelled economic scalars by rating. (American Academy of Actuaries, 2015)

<table>
<thead>
<tr>
<th>Rating</th>
<th>Continued Contraction</th>
<th>Contraction</th>
<th>Expansion</th>
<th>Continued Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aaa</td>
<td>274.9%</td>
<td>274.95%</td>
<td>73.65%</td>
<td>73.65%</td>
</tr>
<tr>
<td>Aa1</td>
<td>274.09%</td>
<td>274.09%</td>
<td>73.42%</td>
<td>73.42%</td>
</tr>
<tr>
<td>Aa2</td>
<td>274.82%</td>
<td>274.82%</td>
<td>73.61%</td>
<td>73.61%</td>
</tr>
<tr>
<td>Aa3</td>
<td>273.78%</td>
<td>273.78%</td>
<td>73.34%</td>
<td>73.34%</td>
</tr>
<tr>
<td>A1</td>
<td>272.87%</td>
<td>272.87%</td>
<td>73.09%</td>
<td>73.09%</td>
</tr>
<tr>
<td>A2</td>
<td>272.14%</td>
<td>272.14%</td>
<td>72.90%</td>
<td>72.90%</td>
</tr>
<tr>
<td>A3</td>
<td>272.52%</td>
<td>272.52%</td>
<td>73.00%</td>
<td>73.00%</td>
</tr>
<tr>
<td>Baa1</td>
<td>322.31%</td>
<td>214.79%</td>
<td>113.01%</td>
<td>73.81%</td>
</tr>
<tr>
<td>Baa2</td>
<td>322.24%</td>
<td>214.75%</td>
<td>112.99%</td>
<td>73.80%</td>
</tr>
<tr>
<td>Baa3</td>
<td>322.79%</td>
<td>215.11%</td>
<td>113.18%</td>
<td>73.92%</td>
</tr>
<tr>
<td>Ba1</td>
<td>297.28%</td>
<td>194.22%</td>
<td>83.81%</td>
<td>81.89%</td>
</tr>
<tr>
<td>Ba2</td>
<td>297.38%</td>
<td>194.29%</td>
<td>83.84%</td>
<td>81.92%</td>
</tr>
<tr>
<td>Ba3</td>
<td>297.27%</td>
<td>194.21%</td>
<td>83.81%</td>
<td>81.89%</td>
</tr>
<tr>
<td>B1</td>
<td>221.14%</td>
<td>149.58%</td>
<td>119.01%</td>
<td>86.17%</td>
</tr>
<tr>
<td>B2</td>
<td>221.12%</td>
<td>149.64%</td>
<td>119.05%</td>
<td>86.20%</td>
</tr>
<tr>
<td>B3</td>
<td>221.14%</td>
<td>149.58%</td>
<td>119.01%</td>
<td>86.17%</td>
</tr>
<tr>
<td>Ca1</td>
<td>223.88%</td>
<td>180.42%</td>
<td>91.00%</td>
<td>85.49%</td>
</tr>
<tr>
<td>Ca2</td>
<td>223.71%</td>
<td>180.28%</td>
<td>90.93%</td>
<td>85.42%</td>
</tr>
<tr>
<td>Ca3</td>
<td>223.56%</td>
<td>180.16%</td>
<td>90.87%</td>
<td>85.36%</td>
</tr>
</tbody>
</table>

Given the fundamental nature of the economic state model in generating the factors, as well as potential limitations referenced in prior sections (Section 3.1, Default Rates, in particular, and subsequent sections, Section 5.2, Correlation, in particular), we recommend a more holistic review for a framework choice that can address a broader set of issues and would allow for more precise differentiation across asset classes and also more accurately capture issues related to the time-series dynamics discussed here.

In particular, and, as discussed in Section 3.1 and references therein, there have been material improvements in techniques and data availability to more accurately capture nuanced time series dynamics for rating migration and default across credit environments that address the observed path-dependency behavior of ratings, and more accurately model correlated recovery dynamics. These approaches are used in practice for a wide range of related applications and at a wide range of organization types. Moody’s Analytics recommends exploring these approaches.
4.2 Portfolio Adjustment Factors

4.2.1 Summary of Moody’s Analytics Significant Areas of Review and Recommendations

The portfolio adjustment factor is one of the most important elements of the model, as it ultimately determines the general RBC level for individual insurers. Unfortunately, documentation is limited, making it difficult to assess the materiality of some of the modeling choices. In addition, the limited documentation available suggests a potential material gap between the calculated C1 factor and its target level for individual insurers, especially smaller ones. Moody’s recommends: (1) more detailed documentation of the adjustment factor and the underlying economic justification, in conjunction with the doubling of C1 factors for the top-10 largest issuers; (2) further exploring the data and methods used to estimate the portfolio adjustment factors, to ensure they are effective for corporate as well as non-corporate issuers, (3) design the factors to align incentives with the economic risks, and (4) design a structure that brings together the portfolio adjustment factors along with the doubling of C1 of the 10 largest issuers.

4.2.2 Review and Analysis Performed by Moody’s Analytics

The base C1 factors reported in Table 4 represent the capital required for the representative portfolio described in Section 3.4 for each rating category. As recognized in the C1 Factor Proposal, an individual insurer’s portfolio can differ significantly from the representative portfolio in rating composition, number of bonds, and holding amount of each bond. Hence, adjustment to the base C1 factor according to the individual insurer’s portfolio characteristics is needed to avoid significant over/under capitalization. There are two proposed adjustments.

First, the C1 factors of the 10 largest issuers held across all debt related asset classes are doubled. The initial filter excludes bonds with C1 RBC equal to 0 and NAIC 1 bonds. As applicable after the first filter, if a top-10 issuer has NAIC 1 bonds, they are added back. Up to 10 bond issuers of a bond portfolio can be subject to the top-10 doubling rule for concentration risk.

Second, the proposed guidelines also include updated base C1 factor adjustment in the form of a scaling factor that is a function of the number of unique issuers in an individual insurer’s portfolio (see Table 5 for details). Regrettably, there is very limited documentation on exactly how these adjustment factors are calculated. To supplement our knowledge, we conducted several interviews with the ACLI and its members. Our best understanding is that the adjustment factors are calibrated roughly according to the following steps:

1. Collect the bond portfolios from 677 actual life insurers.
2. Run the simulation model described in Section 5.2 on these portfolios to determine the capital required to cover 96th percentile statistical safety level for each portfolio.
3. Determine the RBC for each bond in a portfolio using the base C1 factor reported in Table 4, multiplied by the scaling factor, which is tiered according to the number of issuers. Solve a set of optimal scaling factors, one for each portfolio size bucket (i.e., unique issuers in the portfolio), so that the scaled portfolio RBC matches the capital required from the simulation in Step 2 as closely as possible across all 677 portfolios.

While Moody’s Analytics recognizes the importance of these adjustments, we are left questioning the economic justifications of the modeling choices and their materiality:

1. Doubling of capital for the top-10 issuers:
   a. The treatment to double the base C1 factors for top-10 issuers seems arbitrary, why “10”, and not, say “20”? why “double”, and not, say, “triple”. In addition, it is also not clear why this treatment is needed on top of the portfolio adjustment factors.

2. The portfolio adjustment formula:
   a. “Issuer count” is a relatively coarse measure of diversification. While the portfolios used in estimating the relationships between the number of issuers and the cited adjustment factors may have exhibited the cited relationship, there is an incentive to manipulate portfolio composition by holding a small amount in many issuers, which can impact solvency risks. Ideally, the adjustment should align incentives with the economic risks. In this case, concentration is impacted by the total exposure to an issuer, as well as issuer characteristics, including default probability and terms and conditions, including maturity and expected recovery.
   b. The criteria determining the portfolio adjustment factor algorithm are not documented clearly, even though the factors have been updated multiple times. (American Academy of Actuaries, 2016), in June 2017 (American Academy of Actuaries, 2017) and in October 2017 (American Academy of Actuaries, 2017). The final portfolio RBC using the portfolio adjustment factor may deviate substantially from the actual capital needed for some insurer’s portfolio, even though, on average, the gap may be small. We note, that in a presentation deck.
prepared by Academy (Bennett & Owens, 2016), analysis is done comparing the C1 factors after the adjustment against the target level for all 677 portfolios based on an early version of the model. Figure 4 presents analysis results. Due to scaling issues, it is difficult for us to discern from the figure the exact magnitude of the gaps. It appears to be the case though that the gap, on a percentage scale, is larger for smaller sized portfolios, given that the dollar amount of the gap seems relatively flat across different portfolio sizes.

**Figure 4: Difference to Portfolio Target C1 Factor**

With no access to the underlying portfolios, and limited access to validation and backtesting that examines the appropriateness of doubling capital for the top-10 issuers, or the adjustment factors, especially for smaller portfolios, it is difficult for us to weigh in on the materiality of this issue directly. Rather, we conduct a set of stylized case studies described below.

The stylized case studies assess materiality of issuer diversification on portfolio risk. While the exercise quantifies issuer diversification effects, the simplifying assumptions are broad and provide indicative guidance for additional analysis — worth noting, the exercise abstracts from heterogeneity in notional (holding amount), maturity effects, as well as diversification across industry and asset class discussed elsewhere in this report. If the intent of the portfolio adjustment factors is to capture a more comprehensive set of diversification factors beyond issuer, then this exercise should be redesigned.

Table 17 presents portfolio adjustment formula calibrated to highly stylized Moody’s data and based on the standard deviation of losses for hypothetical A2 and Ba1 rated credit portfolios, with the adjustment normalized to the portfolio with 500 issuers. Each portfolio is analyzed separately, and all issuers are homogeneous with equal notional (weight) and with the following characteristics:

- Moody’s Idealized Default Probabilities, as specified in Table 7
- 0% recovery
- Moody’s Analytics GCcorr-implied one-step average pairwise default correlations for a sample of Moody’s corporate rated issuers, noting that other asset classes can exhibit very different pairwise correlation patterns.\(^{16}\)
  - A2 One-Year 0.6%
  - A2 Ten-Year 6.2%
  - Ba1 One-Year 3.1%
  - Ba1 Ten-Year 9.9%

We now compare how the factor adjustments relate to the number of issuers. Exploring the doubling the C1 for the 10 largest issuers, we can see the first 10 issuers of the One-Year A1 portfolio exhibits a risk level 3.13 times the level of the normalized 501\(^{16}\).

---

16 See Moody’s Analytics, 2008 for detailed methodology and validation.
Moving on to the portfolio adjustment factors, we see that for the aforementioned stylized homogeneous portfolios, most of the diversification is achieved with 200 issuers; increasing the number of issuers from 200 to 500 reduces the A2 One-Year adjustment by 2%, with limited diversification beyond 500.

Given the stylized nature of our exercise, as well as the limited access we had to the model and underlying data, we will not draw hard conclusions from comparing Table 17 against Table 5 that would suggest the proposed portfolio adjustment factors do appear to overly penalize insurers with smaller portfolios, a concern that has been echoed by the insurance industry. Rather, we interpret the stylized portfolio results in Table 17 as providing indicative guidance for needed additional analysis.

### Table 17: Portfolio Adjustment Formula Calibrated to Stylized Moody's Data for One- and Ten-Year Horizons

<table>
<thead>
<tr>
<th>Number of Issuers</th>
<th>A2</th>
<th></th>
<th>Ba1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One-Year</td>
<td>Ten-Year</td>
<td>One-Year</td>
<td>Ten-Year</td>
</tr>
<tr>
<td>Up to 10</td>
<td>3.13</td>
<td>1.43</td>
<td>1.79</td>
<td>1.30</td>
</tr>
<tr>
<td>Next 90</td>
<td>1.17</td>
<td>1.01</td>
<td>1.03</td>
<td>1.00</td>
</tr>
<tr>
<td>Next 100</td>
<td>1.02</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Next 300</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Over 500</td>
<td>0.99</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
</tbody>
</table>

With these observations in hand, Moody’s recommends: (1) more detailed documentation of the portfolio adjustment factors, the underlying economic justification in conjunction with the doubling of C1 factors for the top-10 largest issuers; (2) further exploring the data and methods used to estimate the portfolio adjustment factors, and ensuring they are effective for corporate as well as non-corporate issuers; (3) designing the factors to align incentives with the economic risks; and (4) designing a structure that brings together the portfolio adjustment factors along with the doubling of C1 of the ‘10 largest issuers.

### 4.3 Risk Premium

#### 4.3.1 Summary of Moody’s Analytics Significant Areas of Review and Recommendations

The current assumption of setting the Risk Premium equal to expected loss appears to be overly conservative. While the C1 Factor Proposal recognizes the inconsistency, it points out that the 1992 guidelines defined the Risk Premium in this way, and in conjunction with other parameters, some of which (e.g., AVR) are beyond the scope of this report. While Moody’s appreciates the desire to incorporate conservativeness into assumptions, inputs for which accurate proxies are available should be directly used, and rather incorporate the conservative overlay into the final steps to facilitate model transparency. Moody’s recommends a broader evaluation of the various interconnected modeling decisions that lead to setting the Risk Premium at the expected loss level, and aligning the models with a general consensus across the actuarial community, including setting the Risk Premium at a one standard deviation loss.

#### 4.3.2 Review and Analysis Performed by Moody’s Analytics

The level of Risk Premium is an important assumption in the calculation of C1 factors. All else equal, the higher the Risk Premium, the lower C1 factors. While the C1 Factor Proposal recognizes the general consensus within the actuarial community that statutory reserves should at least cover moderately adverse loss, which is proxied as a one standard deviation loss [American Academy of Actuaries, 2015], the Risk Premium is set at expected credit loss, calculated as the sum of the product of baseline marginal default rate and average LGD from Years 1–10, with consideration of discounting, tax, and recoverable tax from loss.

While the authors of the C1 Factor Proposal recognize the inconsistency, they point out that the 1992 guidelines defined the Risk Premium in this way and in conjunction with other parameters, some of which (e.g., AVR) are beyond the scope of this report.
Moody’s recommends a broader evaluation of the various interconnected modeling decisions that lead to setting the Risk Premium at the expected loss level, and aligning the models with general consensus across the actuarial community, including setting the Risk Premium at a one standard deviation loss. This change should allow for better model transparency and consistency. This issue may be worth considering, along with the pending update to Statutory Accounting Principles that will likely be more aligned with CECL.

5 Key Elements Outside of the Defined Scope

This section reviews the assumptions and methodologies that were out of the Defined Scope. Section 5.1 reviews the applicability of using data based on Moody’s rated corporate bonds on all asset classes. Section 5.2 explores the simulation and correlation assumptions. Section 5.3 examines the maturity effect. Section 5.4 reviews the need to more explicitly account for interest income offsets. Section 5.5 discusses the impact of the difference in NRSRO ratings.

5.1 Applicability of Moody’s Rated Corporate Data to Other Asset Classes

5.1.1 Summary of Moody’s Analytics Significant Areas of Review and Recommendations

C1 RBC base factors were developed using Moody’s default rate data on public corporate bond supplemented with S&P’s recovery data. After controlling for ratings, we find material differences in observed default, migration, and recovery dynamics across asset classes. These differences question the effectiveness of using Moody’s rated public corporate bond data for all asset classes. In the following subsections, we report in more detail our findings related to municipal bonds, structured assets, and private placements.

5.1.2 Municipal Bonds

This section assesses default and recovery dynamics and their comparability to corporate bonds. We first explore differences in default and recovery patterns and later explore data nuances. The authors of the C1 Factor Proposal explained the decision of not developing separate C1 factors for municipal bonds by citing "not able to locate any credible or reliable default or recovery studies (of municipals)". The authors also noted that the rating agencies did not update default studies based on calibrated ratings referencing the recalibration of municipal ratings to the global rating scale by Moody’s Investors Service in 2010 (American Academy of Actuaries, 2018). However, there have been material developments in the research of municipal bonds referencing the recalibrated ratings. As a starting point, we cite the observations from a recent study that explores all types of Moody’s rated municipal bonds between 1970 and 2019, and bases its findings on re-calibrated historical ratings of municipal bonds to the global rating scale for comparability with corporates (Moody's Investors Service, 2020). The study finds municipal bonds have: (1) experienced lower default rates, (2) lower rates of rating transitions, and (3) higher recovery rates, than corporate bonds. These observations may not be completely surprising, given municipal and corporate entities are driven by different key rating factors, which are attributed to the different fundamental strengths, weaknesses, and the inherent nature of each sector (Moody’s Investors Service, 2010), as demonstrated by their default patterns, which diverge from corporate borrowers, as seen in Table 18.

Delving into the differences:

First, after controlling for rating, historically municipal credits experienced significantly lower cumulative default rates (CDRs), on average, than corporates. These CDRs are calculated by grouping credits by their rating on a particular date into cohorts and then tracking their performance over time, similar to the cohort approach used in the C1 Factor Proposal. Cohorts are formed at monthly frequencies and then averaged over a year. For example, if a credit is rated Aaa on January 1, 2014, it would be grouped into a cohort of other credits rated Aaa on that date, regardless of its original rating (Moody’s Investors Service, 2020). Municipal bonds have lower or equal CDRs than global corporate across all horizons and rating categories, as shown in Table 18. Using the ten-year CDR, relevant when comparing with the C1 RBC factor model, investment-grade global corporate (2.25%) is significantly higher than that of municipal credits (0.1%). For speculative-grade, the CDR of global corporate (28.68%) is about four times the value of municipal credits (7.29%).
Second, the rating migration of municipal credits differs remarkably from corporate. Municipal ratings are more stable than corporate ratings over the one-year horizon, 1970–2019, as shown in Table 19. For example, on average, 94.63% of Aa rated municipal credit, where most reside, remain in the same rating category over one-year intervals, while only 85.3% of corporate credit does so.

Table 18: Cumulative default rates of municipals and corporate rated by Moody's Investors Service

<table>
<thead>
<tr>
<th>Rating</th>
<th>Average cohort count</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6</th>
<th>Year 7</th>
<th>Year 8</th>
<th>Year 9</th>
<th>Year 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aa</td>
<td>1,003</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>A</td>
<td>6,980</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.00%</td>
<td>0.02%</td>
<td>0.02%</td>
<td>0.00%</td>
<td>0.02%</td>
</tr>
<tr>
<td>Ba</td>
<td>4,873</td>
<td>0.00%</td>
<td>0.01%</td>
<td>0.02%</td>
<td>0.03%</td>
<td>0.04%</td>
<td>0.05%</td>
<td>0.06%</td>
<td>0.09%</td>
<td>0.10%</td>
<td>0.10%</td>
</tr>
<tr>
<td>Ab</td>
<td>675</td>
<td>0.03%</td>
<td>0.11%</td>
<td>0.21%</td>
<td>0.34%</td>
<td>0.47%</td>
<td>0.61%</td>
<td>0.74%</td>
<td>0.87%</td>
<td>0.99%</td>
<td>1.10%</td>
</tr>
<tr>
<td>B</td>
<td>111</td>
<td>0.24%</td>
<td>0.67%</td>
<td>1.10%</td>
<td>1.98%</td>
<td>1.98%</td>
<td>2.28%</td>
<td>2.64%</td>
<td>2.99%</td>
<td>3.30%</td>
<td>3.57%</td>
</tr>
<tr>
<td>Caa-C</td>
<td>23</td>
<td>2.77%</td>
<td>5.48%</td>
<td>8.09%</td>
<td>10.14%</td>
<td>11.31%</td>
<td>12.25%</td>
<td>12.66%</td>
<td>14.71%</td>
<td>15.46%</td>
<td>16.30%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rating</th>
<th>Average cohort count</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6</th>
<th>Year 7</th>
<th>Year 8</th>
<th>Year 9</th>
<th>Year 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aa</td>
<td>105</td>
<td>0.00%</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.03%</td>
<td>0.08%</td>
<td>0.13%</td>
<td>0.18%</td>
<td>0.24%</td>
<td>0.30%</td>
<td>0.36%</td>
</tr>
<tr>
<td>A</td>
<td>879</td>
<td>0.05%</td>
<td>0.16%</td>
<td>0.33%</td>
<td>0.51%</td>
<td>0.73%</td>
<td>0.96%</td>
<td>1.24%</td>
<td>1.52%</td>
<td>1.81%</td>
<td>2.11%</td>
</tr>
<tr>
<td>Ba</td>
<td>847</td>
<td>0.16%</td>
<td>0.41%</td>
<td>0.72%</td>
<td>1.10%</td>
<td>1.47%</td>
<td>1.86%</td>
<td>2.24%</td>
<td>2.65%</td>
<td>3.09%</td>
<td>3.58%</td>
</tr>
<tr>
<td>B</td>
<td>461</td>
<td>0.58%</td>
<td>2.40%</td>
<td>4.14%</td>
<td>6.01%</td>
<td>7.77%</td>
<td>9.44%</td>
<td>10.93%</td>
<td>12.36%</td>
<td>13.86%</td>
<td>15.40%</td>
</tr>
<tr>
<td>Caa-C</td>
<td>562</td>
<td>3.26%</td>
<td>7.71%</td>
<td>12.32%</td>
<td>16.52%</td>
<td>20.53%</td>
<td>23.69%</td>
<td>26.98%</td>
<td>29.37%</td>
<td>31.66%</td>
<td>33.70%</td>
</tr>
<tr>
<td>Aa</td>
<td>337</td>
<td>9.68%</td>
<td>17.19%</td>
<td>23.56%</td>
<td>28.95%</td>
<td>33.56%</td>
<td>37.24%</td>
<td>40.41%</td>
<td>43.52%</td>
<td>45.89%</td>
<td>47.95%</td>
</tr>
<tr>
<td>A</td>
<td>2,241</td>
<td>0.08%</td>
<td>0.23%</td>
<td>0.42%</td>
<td>0.64%</td>
<td>0.89%</td>
<td>1.14%</td>
<td>1.40%</td>
<td>1.67%</td>
<td>1.96%</td>
<td>2.25%</td>
</tr>
<tr>
<td>Ba</td>
<td>1,360</td>
<td>3.56%</td>
<td>8.05%</td>
<td>11.50%</td>
<td>15.33%</td>
<td>18.34%</td>
<td>20.91%</td>
<td>23.14%</td>
<td>25.15%</td>
<td>26.98%</td>
<td>28.68%</td>
</tr>
<tr>
<td>B</td>
<td>3,801</td>
<td>1.53%</td>
<td>3.04%</td>
<td>4.43%</td>
<td>5.64%</td>
<td>6.67%</td>
<td>7.54%</td>
<td>8.29%</td>
<td>8.96%</td>
<td>9.59%</td>
<td>10.17%</td>
</tr>
</tbody>
</table>
Table 19: Average one-year rating transition rates of municipals and corporate rated by Moody’s Investors Service

Municipal ratings transition less frequently than global corporates
Average one-year rating transition rates, 1970-2019, municipal vs. global corporate issuers

<table>
<thead>
<tr>
<th>From/To</th>
<th>Aaa</th>
<th>Aa</th>
<th>A</th>
<th>Ba</th>
<th>B</th>
<th>Caa-C</th>
<th>Withdrawn</th>
<th>Default</th>
</tr>
</thead>
<tbody>
<tr>
<td>Municips</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aaa</td>
<td>1,003</td>
<td>94.81%</td>
<td>1.91%</td>
<td>0.11%</td>
<td>0.03%</td>
<td>0.01%</td>
<td>0.03%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Aa</td>
<td>6,980</td>
<td>94.63%</td>
<td>1.63%</td>
<td>0.02%</td>
<td>0.01%</td>
<td>0.03%</td>
<td>0.00%</td>
<td>3.97%</td>
</tr>
<tr>
<td>A</td>
<td>4,673</td>
<td>92.73%</td>
<td>0.51%</td>
<td>0.13%</td>
<td>0.01%</td>
<td>0.00%</td>
<td>4.67%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Ba</td>
<td>676</td>
<td>0.02%</td>
<td>3.39%</td>
<td>69.41%</td>
<td>1.72%</td>
<td>0.21%</td>
<td>0.04%</td>
<td>5.18%</td>
</tr>
<tr>
<td>B</td>
<td>111</td>
<td>0.04%</td>
<td>0.22%</td>
<td>2.10%</td>
<td>4.81%</td>
<td>80.43%</td>
<td>2.74%</td>
<td>0.65%</td>
</tr>
<tr>
<td>Caa-C</td>
<td>11</td>
<td>0.00%</td>
<td>0.20%</td>
<td>0.90%</td>
<td>1.02%</td>
<td>5.61%</td>
<td>76.13%</td>
<td>5.35%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>From/To</th>
<th>Aaa</th>
<th>Aa</th>
<th>A</th>
<th>Ba</th>
<th>B</th>
<th>Caa-C</th>
<th>Withdrawn</th>
<th>Default</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Corporates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aaa</td>
<td>105</td>
<td>87.90%</td>
<td>7.79%</td>
<td>0.59%</td>
<td>0.07%</td>
<td>0.02%</td>
<td>0.03%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Aa</td>
<td>411</td>
<td>85.30%</td>
<td>8.46%</td>
<td>0.42%</td>
<td>0.06%</td>
<td>0.03%</td>
<td>0.02%</td>
<td>4.90%</td>
</tr>
<tr>
<td>A</td>
<td>679</td>
<td>66.59%</td>
<td>5.18%</td>
<td>0.40%</td>
<td>0.10%</td>
<td>0.04%</td>
<td>4.63%</td>
<td>0.02%</td>
</tr>
<tr>
<td>Ba</td>
<td>647</td>
<td>4.62%</td>
<td>66.12%</td>
<td>3.59%</td>
<td>0.65%</td>
<td>0.16%</td>
<td>5.15%</td>
<td>0.16%</td>
</tr>
<tr>
<td>B</td>
<td>461</td>
<td>0.04%</td>
<td>0.40%</td>
<td>6.14%</td>
<td>76.53%</td>
<td>7.09%</td>
<td>0.81%</td>
<td>9.25%</td>
</tr>
<tr>
<td>Caa-C</td>
<td>337</td>
<td>0.01%</td>
<td>0.13%</td>
<td>0.44%</td>
<td>4.84%</td>
<td>73.07%</td>
<td>7.05%</td>
<td>10.61%</td>
</tr>
</tbody>
</table>

Third, Average issuer-weighted recoveries on Moody’s-rated municipal bonds since 1970 have been about 68%, significantly higher than the issuer-weighted average 47.7% ultimate recovery rate for senior unsecured bonds of North American corporate issuers since 1987 (Moody’s Investors Service, 2020 (2)).

We now discuss nuances with the data (referenced in the Moody’s study) that should be recognized if used in estimating distinct municipal C1 factors.

First, municipal credits are concentrated heavily in investment-grade (see Figure 5). The average proportion of investment-grade for municipal bonds 1970–2019 is 98.9%, while only 62.2% of corporate bonds are rated investment-grade during the same period. Since there is a limited number of speculative-grade municipal bonds, data from other asset classes may be needed, should a separate model be developed for munipals.

Figure 5: Distribution of Moody’s Investors Service Ratings for Municipal Credits (1969–2019)

Source: (Moody’s Investors Service, 2020 (2))
Second, prior to 2010, municipal bonds were rated using the municipal rating scale, different from the corporate rating scale. Moody’s municipal ratings were recalibrated to the global rating scale in May 2010, in order to enhance the comparability of ratings across Moody’s rated asset classes. Historical municipal ratings have been adjusted to the global rating scale to ensure comparability of ratings before and after the 2010 rating recalibration exercise. The historical municipal ratings before mid-2010 were first shifted by the average notch of rating shift, by municipal rating scale and sector. If a credit’s adjusted rating immediately before the recalibration in mid-2010 differs from its realized recalibrated rating, then the realized recalibrated rating will be extended back to the last rating action date before April 2010. Appendix G of the referenced study (Moody’s Investors Service, 2020 (2)) provides a detailed adjustment methodology for historical municipal ratings.

With these observations in mind, Moody’s Analytics recommends using municipal default, migration, and recovery data in estimating distinct C1 factors for municipal credit.

5.1.3 Structured Assets

This section assesses the default and recovery dynamics of structured assets and their comparability to corporate bonds. We also evaluate the variations among structured sectors, before and after the Great Recession. As a starting point, we cite the observations from recent studies that explore Moody’s rated structured assets between 1993 and 2020 and the underlying data. The studies find marked differences in risk dynamics for structured assets issued on or after January 1, 2009. For the entire study period 1993–2020, structured assets have: (1) experienced higher impairment rates,17 (2) higher net rating downgrade rates,18 and (2) lower recovery rates than corporate bonds. For post-2009 issuance,19 structured assets have (1) close-to-zero impairment rates and (2) high net rating upgrade rates. These observations may not be completely surprising, given that structured assets experienced severe loss during the Great Recession, and regulations and market surveillance have strengthened over the past decade. We note that structured assets and corporate entities are driven by different key rating factors, which are attributed to the different fundamental strengths, weaknesses, and the inherent nature of each sector (Moody’s Investors Service, 2020 (3)). Moody’s differentiates structured finance ratings from fundamental ratings (i.e., ratings on nonfinancial corporate, financial institution, and public sector entities) on the global long-term scale by adding (sf) to all structured finance ratings. The addition of (sf) to structured finance ratings should eliminate any presumption that such ratings and fundamental ratings at the same letter grade level will behave the same. The (sf) indicator for structured finance security ratings indicates that otherwise similarly rated structured finance and fundamental securities may have different risk characteristics. Through its current methodologies, however, Moody’s aspires to achieve broad, expected equivalence in structured finance and fundamental rating performance when measured over a long period of time.

Delving into the differences:

First, structured assets have remarkably higher impairment rates than the global corporate, based on historical experiences 1993–2020 (see Table 20). For U.S. RMBS/CMBS/ABS, the impairment rates are at least multiple times higher than the corporate default rate, with U.S. RMBS on average comprising more than half of structured tranches 1993–2020h1. Only Global CLOs have lower impairment rates than corporate.

---

17 Due to the unique nature of structured assets, impairment is commonly used to describe the financial loss events. A security is impaired when investors receive — or expect to receive with near certainty — less value than would be expected if the obligor were not experiencing financial distress or otherwise prevented from making payments by a third party, even if the indenture or contractual agreement does not provide the investor with a natural remedy for such events, such as the right to press for bankruptcy (Moody’s Investors Service, 2020 (1)). There are two types of impairments — principal impairments and interest impairments. Securities with principal impairments are those that have not yet experienced an interest shortfall or principal write-downs or losses greater than 50 basis points (bps) of the tranche original balance or securities currently carrying C or C ratings, even if they have not yet experienced an interest shortfall or principal write-down. Securities with interest impairments, or interest-impaired securities, are those that are not principal impaired but have outstanding interest shortfalls greater than 50 bps of the tranche original balance. Because interest shortfalls are cured at fairly high frequency within a short period, we record an interest impairment only if the 50 bps shortfall has been outstanding for 12 months or longer (Moody’s Investors Service, 2020 (1)). The vast majority of impairments are principal impairments.

18 Net rating downgrade rate refers to the difference between 12-month average rating downgrade rate and upgrade rate.

19 Post-2009 issuance refers to structured asset securities issued on or after January 1, 2009.
Table 20: Average one-year default/impairment rate of securities rated by Moody’s Investors Service

<table>
<thead>
<tr>
<th>Rating</th>
<th>Global Corporate*</th>
<th>US RMBS**</th>
<th>US CMBS**</th>
<th>US ABS**</th>
<th>Global CLO**</th>
<th>All Structured Finance***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aaa</td>
<td>0.00%</td>
<td>0.59%</td>
<td>0.02%</td>
<td>0.03%</td>
<td>0.00%</td>
<td>0.46%</td>
</tr>
<tr>
<td>Aa</td>
<td>0.02%</td>
<td>4.74%</td>
<td>0.08%</td>
<td>0.20%</td>
<td>0.00%</td>
<td>2.76%</td>
</tr>
<tr>
<td>A</td>
<td>0.05%</td>
<td>5.49%</td>
<td>0.27%</td>
<td>0.17%</td>
<td>0.01%</td>
<td>3.00%</td>
</tr>
<tr>
<td>Baa</td>
<td>0.16%</td>
<td>9.31%</td>
<td>0.84%</td>
<td>0.50%</td>
<td>0.06%</td>
<td>5.70%</td>
</tr>
<tr>
<td>Ba</td>
<td>0.84%</td>
<td>12.37%</td>
<td>3.66%</td>
<td>2.30%</td>
<td>0.14%</td>
<td>7.88%</td>
</tr>
<tr>
<td>B</td>
<td>3.04%</td>
<td>14.96%</td>
<td>7.77%</td>
<td>5.91%</td>
<td>0.50%</td>
<td>11.95%</td>
</tr>
<tr>
<td>Caa-C</td>
<td>8.89%</td>
<td>20.40%</td>
<td>23.92%</td>
<td>16.43%</td>
<td>2.45%</td>
<td>19.81%</td>
</tr>
</tbody>
</table>

*global corporate default rate 1970-2019
**structured asset impairment rate by sector 1993-2020h1
***impairment rate for all structured assets 1993-2020h1
Source: Moody’s Investors Service

In contrast, for post-2009 issuance, impairments become rare. The average one-year impairment is only 0.04% 2009–2019. U.S. RMBS, U.S. ABS, and Global CLOs even have zero impairment (see Table 21). There have been notable changes that may contribute to this strong performance (S&P Global, 2019).

» Regulation
  - Increased disclosure requirements, for instance, the simple, transparent, and standardized (STS) designation.
  - New risk retention rules for certain sectors, such as the 5% risk retention requirement for originators, and increased regulatory capital charges for some investors.
  - Limits to the origination of certain products, such as self-certified mortgages in the U.K., and increased focus on loan affordability, such as the ability-to-repay (ATR)/qualified mortgage (QM) rule in the U.S.

» Market structure
  - Shift toward nonbank sponsors and emergence of private portfolio lenders.
  - Less use of leverage by investors and more "buy and hold" investments.
  - Decreased rated issuance compared to pre-crisis levels.

» Securitization structures
  - More sequential pay structures which, all else equal, provide more protection to senior bondholders.
  - Generally, more seasoned and less leveraged structures.
  - Certain structures, such as subprime RMBS and CDOs of ABS, have broadly disappeared.

20 The default/impairment rates are the fractions of default/impairment from the empirical one-year rating transition matrices for global corporate and structured asset classes provided by Moody’s Investors Service.
21 CDOs of ABS are securities backed by a collateral pool made of other structured tranches. This is different from conventional ABS, such as ABS backed by student loans.
Second, the rating transition rates differ between structured assets and corporate, as well as among structured sectors. Given the relatively large number of structured sectors, Table 22 presents and summarizes the 12-month downgrade and upgrade rates for all structured securities issued in 1993–2020. Table 23 shows structured securities issued since 2009. We include Global Corporate's Corporate statistics 1984–2020 for comparison. As seen in Table 22, Global Structured Finance, overall, have a higher downgrade rate and a lower upgrade rate than Global Corporate (Hist avg. column). This appears to be driven by the performance of U.S. RMBS and Global CDOs. Excluding both sectors, Global Structured Finance has net downgrade rates of approximately 1.02% lower than Global Corporate (4.2%). Understandably, U.S. RMBS and Global CDOs were the most severely impacted sectors during the Great Recession.

In contrast, for structured securities issued since 2009 (see Table 23), Global Structured Finance has significantly lower downgrade rates (2.09%) 2009–2020 than Global Corporate (13.63%), while upgrade rates of both sectors are not very different. Remarkably, more Global Structured Finance ratings are upgraded than downgraded. On average, Global Structured Finance ratings have a net upgrade rate of 6.3%, while Global Corporate has a net downgrade rate of 4.2%.

---

**Table 21: 12-month impairment rate for structured tranches issued on or after January 1, 2009 and rated by Moody’s Investors Service 2009–2019**

<table>
<thead>
<tr>
<th>Sector</th>
<th>Impairment rate</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This year*</td>
<td>5-year avg. **</td>
</tr>
<tr>
<td>US ABS</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>US RMBS</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>US CMBS</td>
<td>0.00%</td>
<td>0.12%</td>
</tr>
<tr>
<td>Global CDOs ex CLOs</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Global CLOs</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>EMEA SF ex CDO &amp; Other</td>
<td>0.00%</td>
<td>0.03%</td>
</tr>
<tr>
<td>Intl SF ex CDO &amp; Other</td>
<td>0.00%</td>
<td>0.17%</td>
</tr>
<tr>
<td>Other SF</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Global SF</td>
<td>0.00%</td>
<td>0.04%</td>
</tr>
</tbody>
</table>

* This year covers the 12-month period from 1 January 2019 to 31 December 2019.
** 5-year avg covers the 60-month period from 1 January 2015 to 31 December 2019.
*** Hist. avg. covers the period 1 January 2009 to 31 December 2019.
Source: Moody’s Investors Service

---

22 The period for the corporate average differs, as Moody’s Investors Service compares with a long-term, corporate benchmark.
23 Net downgrade rate is the difference between downgrade rate and upgrade rate.
Table 22: Global structured finance 12-month downgrade and upgrade rates by sector (structured asset securities issued in 1993–2020)

<table>
<thead>
<tr>
<th>Sector</th>
<th>12-month downgrade rate</th>
<th>12-month upgrade rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2020H1*</td>
<td>2019H1*</td>
</tr>
<tr>
<td>US ABS, CMBS, &amp; RMBS</td>
<td>4.93%</td>
<td>2.25%</td>
</tr>
<tr>
<td>US ABS</td>
<td>3.02%</td>
<td>1.73%</td>
</tr>
<tr>
<td>US Auto Loans</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>US Credit Cards</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>US Student Loans</td>
<td>3.57%</td>
<td>2.79%</td>
</tr>
<tr>
<td>US Equipment Lease</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>US RMBS</td>
<td>5.85%</td>
<td>2.27%</td>
</tr>
<tr>
<td>US CMBS</td>
<td>4.38%</td>
<td>2.70%</td>
</tr>
<tr>
<td>excl CRE CDOs</td>
<td>4.44%</td>
<td>2.88%</td>
</tr>
<tr>
<td>EMEA ABS, CMBS, &amp; RMBS</td>
<td>2.85%</td>
<td>6.90%</td>
</tr>
<tr>
<td>Asia-Pacific ABS, CMBS, &amp; RMBS</td>
<td>0.51%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Latin America ABS, CMBS, &amp; RMBS</td>
<td>32.20%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Global CDOs ex CLOs</td>
<td>0.00%</td>
<td>0.92%</td>
</tr>
<tr>
<td>Global CLOs</td>
<td>1.72%</td>
<td>0.54%</td>
</tr>
<tr>
<td>US CLOs</td>
<td>1.77%</td>
<td>0.73%</td>
</tr>
<tr>
<td>EMEA CLOs</td>
<td>1.62%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Global structured finance</td>
<td>3.84%</td>
<td>2.23%</td>
</tr>
<tr>
<td>excl US RMBS and SF CDOs</td>
<td>2.75%</td>
<td>2.17%</td>
</tr>
<tr>
<td>Global corporate</td>
<td>16.37%</td>
<td>8.09%</td>
</tr>
</tbody>
</table>

Source: Moody's Investors Service

Table 23: Global structured finance 12-month downgrade and upgrade rates by sector (structured asset securities issued on or after January 1, 2009)

<table>
<thead>
<tr>
<th>Sector</th>
<th>12-month downgrade rate</th>
<th>12-month upgrade rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2020H1*</td>
<td>2019H1*</td>
</tr>
<tr>
<td>US ABS, CMBS, &amp; RMBS</td>
<td>1.89%</td>
<td>0.75%</td>
</tr>
<tr>
<td>US ABS</td>
<td>1.92%</td>
<td>0.35%</td>
</tr>
<tr>
<td>US Auto Loans</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>US Credit Cards</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>US Student Loans</td>
<td>1.09%</td>
<td>0.32%</td>
</tr>
<tr>
<td>US Equipment Lease</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>US RMBS</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>US CMBS</td>
<td>3.95%</td>
<td>1.71%</td>
</tr>
<tr>
<td>excl CRE CDOs</td>
<td>4.16%</td>
<td>1.79%</td>
</tr>
<tr>
<td>EMEA ABS, CMBS, &amp; RMBS</td>
<td>3.54%</td>
<td>6.08%</td>
</tr>
<tr>
<td>Asia-Pacific ABS, CMBS, &amp; RMBS</td>
<td>0.60%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Latin America ABS, CMBS, &amp; RMBS</td>
<td>85.77%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Global CDOs ex CLOs</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Global CLOs</td>
<td>1.73%</td>
<td>0.55%</td>
</tr>
<tr>
<td>US CLOs</td>
<td>1.77%</td>
<td>0.74%</td>
</tr>
<tr>
<td>EMEA CLOs</td>
<td>1.63%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Global structured finance</td>
<td>2.12%</td>
<td>1.13%</td>
</tr>
<tr>
<td>Global corporate</td>
<td>16.37%</td>
<td>8.09%</td>
</tr>
</tbody>
</table>

Source: Moody’s Investors Service

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Finally, the recovery rates of structured assets are notably different from corporate bonds. Given the scarcity of recovery data for the post-2009 issuance, we present recovery statistics 1993–2019. Moody’s Investors Service examined LGDs for the 24,714 global impairments, for which final resolved loss data is available.

During 1993–2019, the average LGD rate for all resolved principal impaired securities was 84% of the original balance. As seen in Table 24, realized final LGD rates by sector for resolved principal impairments 1993–2019. U.S. RMBS accounts for the vast majority of impairments among all structured asset classes, with U.S. CMBS a distant second. For investment-grade tranches by rating at issuance, U.S. RMBS and CMBS have significantly higher LGDs than U.S. ABS and Global CLOs, with Global CDOs having the highest LGD. For speculative-grade tranches, U.S. ABS and Global CLOs still have lower LGDs than U.S. CMBS.

In comparison, the issuer-weighted average ultimate recovery rate is 47.7% for North American senior unsecured corporate bonds issued since 1987, implying LGD of 52.3% (Moody’s Investors Service, 2020 (2)). U.S. RMBS/CMBS/ABS (both investment-grade and speculative-grade) all have higher LGDs than corporate. The investment-grade Global CLOs have lower LGD than corporate, while the speculative-grade CLOs have higher LGD than corporate.

Table 24: Realized final LGD rates by sector for resolved principal impairments 1993–2019

<table>
<thead>
<tr>
<th>Asset class</th>
<th>Counts</th>
<th>Mean</th>
<th>Counts</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>US ABS</td>
<td>190</td>
<td>59.6%</td>
<td>40</td>
<td>73.5%</td>
</tr>
<tr>
<td>Small Business Loans</td>
<td>69</td>
<td>81.5%</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Franchise Loans</td>
<td>40</td>
<td>74.4%</td>
<td>17</td>
<td>96.0%</td>
</tr>
<tr>
<td>Student Loans</td>
<td>25</td>
<td>12.6%</td>
<td>-</td>
<td>0.0%</td>
</tr>
<tr>
<td>Equipment Leases</td>
<td>41</td>
<td>38.2%</td>
<td>15</td>
<td>47.8%</td>
</tr>
<tr>
<td>US RMBS/HEL/MH</td>
<td>18,447</td>
<td>83.3%</td>
<td>2,258</td>
<td>81.5%</td>
</tr>
<tr>
<td>Alt-A/Option ARM</td>
<td>8,617</td>
<td>82.1%</td>
<td>551</td>
<td>80.7%</td>
</tr>
<tr>
<td>Jumbo</td>
<td>1,001</td>
<td>35.0%</td>
<td>227</td>
<td>44.4%</td>
</tr>
<tr>
<td>HELOC</td>
<td>51</td>
<td>99.6%</td>
<td>20</td>
<td>89.7%</td>
</tr>
<tr>
<td>Scratch &amp; Dent</td>
<td>330</td>
<td>90.9%</td>
<td>64</td>
<td>72.7%</td>
</tr>
<tr>
<td>Subprime Firsts</td>
<td>7,111</td>
<td>89.2%</td>
<td>1,029</td>
<td>88.2%</td>
</tr>
<tr>
<td>Subprime Seconds</td>
<td>983</td>
<td>96.0%</td>
<td>102</td>
<td>94.0%</td>
</tr>
<tr>
<td>Manufactured Housing</td>
<td>109</td>
<td>90.0%</td>
<td>35</td>
<td>95.4%</td>
</tr>
<tr>
<td>US CMBS</td>
<td>769</td>
<td>90.6%</td>
<td>1,291</td>
<td>92.2%</td>
</tr>
<tr>
<td>Conduit/Fusion</td>
<td>611</td>
<td>94.5%</td>
<td>1,187</td>
<td>93.4%</td>
</tr>
<tr>
<td>CRE CDO</td>
<td>67</td>
<td>88.5%</td>
<td>29</td>
<td>73.1%</td>
</tr>
<tr>
<td>Small Balance Commercial</td>
<td>36</td>
<td>81.0%</td>
<td>49</td>
<td>93.2%</td>
</tr>
<tr>
<td>Large Loan</td>
<td>51</td>
<td>60.1%</td>
<td>23</td>
<td>54.5%</td>
</tr>
<tr>
<td>EMEA ABS,CMBS,RMBS</td>
<td>42</td>
<td>54.9%</td>
<td>29</td>
<td>40.0%</td>
</tr>
<tr>
<td>INTL ABS,CMBS,RMBS</td>
<td>52</td>
<td>75.2%</td>
<td>56</td>
<td>95.7%</td>
</tr>
<tr>
<td>Global CLOs</td>
<td>15</td>
<td>34.0%</td>
<td>11</td>
<td>85.6%</td>
</tr>
<tr>
<td>Global CDOs</td>
<td>1,416</td>
<td>91.6%</td>
<td>98</td>
<td>96.6%</td>
</tr>
<tr>
<td>HY CDOs</td>
<td>1,373</td>
<td>91.8%</td>
<td>87</td>
<td>96.9%</td>
</tr>
<tr>
<td>Syn Arbitrage</td>
<td>29</td>
<td>92.8%</td>
<td>na</td>
<td>na</td>
</tr>
</tbody>
</table>

Assets with counts less than 10 are not shown.
Source: Moody’s Investors Service

While Moody’s Analytics recognizes the data challenges and model complexities of modeling the various structured asset classes across historic periods, the observations above are sufficiently stark enough that we recommend assessing the use of structured data on default/impairment, migration, and recovery when estimating distinct C1 factors for structured assets.

5.1.4 Private Placement Credits

This section assesses default and recovery dynamics of private placement credits and their comparability with Moody’s rated corporate bonds. Private placements refer to instruments, issued in reliance on a statutory or rule-based exemption from the registration requirements imposed by the Securities Act of 1933. Broker-dealers that recommend or sell private placements have additional requirements under FINRA and SEC rules, which include filing certain offering documents and ensuring the suitability of
any recommended investments (FINRA, 2021). Private placements are usually unrated by NRSRO but can have equivalent credit
designations from NAIC.

As a starting point, we cite the observations from a recent study that explores the default and recovery experiences of private
placement credits in 2003–2015 (Society of Actuaries, 2019). The study is based on data contributed by 20 insurers over the
2003–2015 period that covers 14,142 CUSIPs. The study finds that, when compared with comparable Moody’s rated corporates:

- Investment-grade private placement credits have experienced similar default rates
- Speculative-grade private placement credits have experienced higher default rates
- Placement credits have different rates of rating transitions
- Placement credits have higher recovery rates

Delving into the differences:

First, investment-grade default rates are low for both private placements issuers (0.15%) and public corporates (0.12%)
respectively (see Figure 6, the investment-grade column). Private issuers have higher default rates for all ratings Baa and lower.
Since the private placement data from the participating companies are heavily skewed towards investment-grade, the overall
default rate for rated bonds is lower for private issuers (0.51%) than Moody’s rated issuers (1.50%). The quality mix difference also
explains why private issuers have lower, overall speculative-grade default rates. The ratings of speculative-grade private issuers are
more concentrated in Ba, while Moody’s rated corporates are more concentrated in B and below.

Figure 6: Average one-year issuer default rates of public versus private issuer25

![Figure 6: Average one-year issuer default rates of public versus private issuer](source)

Source for public bonds: (Moody’s Investors Service, 2018)
Source for private bonds: (Society of Actuaries, 2019)

Second, the rating transition patterns differ between private placements and Moody’s rated corporates. As seen in Table 25,
constructed using the internal ratings of investors, private placements have a significantly higher probability of Withdrawn Rating

24 The default rates of private placement issuers are measured by incident rate of Credit Risk Events (CRE). CRE is parallel to default referenced by rating agencies
except for two other types of events:
- the sale of a private placement bond at a price less than or equal to 70 cents on the dollar
- any other credit event that a contributor substantiated as a default-like credit deterioration but, due to the nuances of the private placement market,
does not fit the definitions above. The purpose of including these types of events as CREs is to avoid understatement of the incidence of CREs for
situations that, in similar circumstances with public bonds, would have most likely resulted in a default.

25 The chart was constructed by the Society of Actuaries, with reference to data from Moody’s Investors Service.
(WR)\textsuperscript{26} than Moody's rated corporates (see Table 26) especially for Aaa and speculative grades. With the exception of Aaa, private placements have similar or lower rating transition rates than Moody's rated corporates for investment grade. For speculative grades, especially B and below, private placements have a higher rate of rating transition than Moody's rated corporates.

Table 25: One-year rating transition rate of private placement credits (2003–2015)

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
<th>Most Recent Internal Ratings One-Year Migration Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aaa</td>
<td>83.65%</td>
<td>4.57%</td>
</tr>
<tr>
<td>Aa</td>
<td>0.73%</td>
<td>88.75%</td>
</tr>
<tr>
<td>A</td>
<td>0.03%</td>
<td>1.03%</td>
</tr>
<tr>
<td>Bbb</td>
<td>0.02%</td>
<td>0.03%</td>
</tr>
<tr>
<td>B</td>
<td>0.01%</td>
<td>0.03%</td>
</tr>
<tr>
<td>Ccc</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Cc-c</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Wr</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Source: (Society of Actuaries, 2019)

Table 26: One-year rating transition rate of public corporates rated by Moody’s Investors Service (1970–2019)

<table>
<thead>
<tr>
<th>From/To</th>
<th>Average cohort count</th>
<th>Aaa</th>
<th>Aa</th>
<th>A</th>
<th>Aaa</th>
<th>Aa</th>
<th>Aaa</th>
<th>Aa</th>
<th>Aaa</th>
<th>Aa</th>
<th>Aaa</th>
<th>Aa</th>
<th>Aaa</th>
<th>Aa</th>
<th>Aaa</th>
<th>Aa</th>
<th>Aaa</th>
<th>Aa</th>
<th>Aaa</th>
<th>Aa</th>
<th>Aaa</th>
<th>Aa</th>
<th>Aaa</th>
<th>Aa</th>
<th>Aaa</th>
<th>Aa</th>
<th>Aaa</th>
<th>Aa</th>
</tr>
</thead>
</table>

Third, the recovery rate of senior unsecured private placements 2003–2015 (62.2%) is higher than the issuer-weighted, average 47.7% ultimate recovery rate for senior unsecured bonds of North American corporate issuers since 1987 (Moody’s Investors Service, 2020 (2)). It is recognized that private placement credits have customized covenant protections to investors (Society of Actuaries, 2019). This could contribute to higher recovery rates for private placement credits than public corporate.

It is noted that the private placements data may be subject to challenges, such as change in asset IDs and miscoded ratings. While the Private Placement Experience Committee at the Society of Actuaries has reviewed and detected the data issues, some errors may remain and affect the rating transition matrices. In addition, the experience data was provided by 20 insurers and may not fully reflect the whole universe.

Since private placement credits have higher default rates for Baa and below ratings and higher recovery rate than what is observed for Moody’s rated corporates, additional data and analysis may be needed to assess whether C1 factors will be larger or smaller than currently proposed if private placement credits data is used for C1 factors development. While recognizing the data challenges and scarcity of references, Moody’s recommends exploring a centralized collection of default, migration, and recovery data that can later be used in further estimating distinct C1 factors and for other purposes.

\textsuperscript{26} Withdrawn Rating (WR) includes the events where assets have matured, been sold, or called. This classification also includes a very small proportion of assets that migrated from a letter rating to no rating submitted by the participating companies in the following year.
5.2 Simulation and Correlation

5.2.1 Summary of Moody’s Analytics Significant Areas of Review and Recommendations
The current C1 factor model does not account for variation in cross-industry and cross-asset class concentration risks nor diversification that may be different across life companies’ portfolios. These variations can be material, and we recommend additional analysis that assesses the materiality of abstracting from cross-industry and cross-asset class differentiation.

5.2.2 Review and Analysis Performed by Moody’s Analytics
The representative portfolio is simulated for each alphanumeric rating when computing C1 factors. For example, the C1 RBC factor for Aaa rated bonds is computed independently of the C1 factor for A or Baa ratings. The simulated economic state determines the leveled economic scalar that adjusts baseline default rates for each counterparty. If a bond defaults in any year $t$ before Year 10, then the full principal is assumed to be reinvested with the same initial rating and maturity $(10-t)$ years. For example, if an Aa1 bond defaults at Year 3, then the full principal is assumed to be reinvested in an Aa1 bond with 7 years maturity. The cashflows are discounted to present value by 5% pre-tax/3.25% after-tax per annum, approximately the average 10-year LIBOR swap rates 1994–2013. The tax rate for assets carried at market value is assumed to be 35%. 80% of tax is assumed to be recoverable when default occurs.

The approach of separately simulating each rating makes sense in the context of stylized sub-portfolios that exhibit no diversification benefits when combined. This is generally not the case with credit portfolios, which often have a range of industry, country, and asset-class (e.g., Muni, corporate) exposures. In addition, setting the representative portfolio as having the same level of counterparty concentration and its impact on portfolio risk is worth exploring further.

To better understand the materiality of cross-asset class diversification benefits, we explore their historical default rates and the extent to which they are correlated.

Figure 7 demonstrates historical default rates of speculative-grade municipal bonds and global corporates are not strongly correlated — if they were, the two series would move in lockstep. For example, during the 2001 dot-com bubble, when the speculative-grade corporate default rate skyrocketed, default of similar-rated municipal bonds remained rare. This follows, as municipal and corporate bonds are driven by different underlying risk factors.

Figure 7: Historical default rate of speculative-grade municipal bonds and global corporates

In a similar vein, Figure 8 presents the average annualized default probability, using the Moody’s Analytics EDF™ (Expected Default Frequency) credit measure, across all U.S. Financial and Non-financial publicly listed firms. We can see the Tech and Telecom companies deteriorated in credit quality during the early 2000s, with financial institutions weathering reasonably well. Financials’ default probabilities increased in a more pronounced manner at the onslaught of the Great Recession, and they have weathered the current COVID-19 crisis reasonably well.
Figure 8: Average One-Year Default Probabilities for Financials and Non-Financial Firms in the United States (normalized so that 2000 probabilities = 1%)

Source: Moody’s Analytics

The desire to model these correlations is recognized in (American Academy of Actuaries, 2015); the methodology and data did not lend to segmentation:

While credit recognized as we considered the use of default rates that varied by industry sector, however, there was limited data available. In addition, there are practical considerations with how to classify bonds by industry. Hypothetically, if sufficient data were available, a model with industry correlation factors could be built. As such data is not available, we assume correlations are implicit in the default data.

We recognize the challenges of using default data for rated corporate borrowers — in particular, the dearth of data limits segmentation. There, however, is a wide range of data and modeling approaches that have been developed to overcome this challenge. Moody’s Analytics GCorr™ global correlation model, for example, contains over 1,000 credit factors, with coverage including corporate credit (61 industries across over 100 countries) also relevant for CLOs, retail credit in the U.S. (with 6 retail asset types across 51 states/district) that is relevant for ABS and RMBS, over 100 sovereigns, and commercial real estate (with 5 property types across 73 MSAs) relevant for CMBS. When used in conjunction with Moody’s Analytics rating transition model we can obtain a granular representation of portfolio risk that accounts for correlated deterioration in credit and default. When used in assessing diversification, we find corporate industry credit factors within each country are, on average, in the order of 85% correlated, but can exhibit correlations as low as 70%. Meanwhile, cross-asset class diversification can be material, with retail, corporate, and commercial real estate factors often having correlations below 50%. While the impact on portfolio risk measures can be substantial, with reductions of in excess of 30%, when imperfect correlations are accounted for, Moody’s recognizes the impact is portfolio-specific and dependent upon the specific nature of the risk measures of interest (e.g., greatest default loss, standard deviation).

We further highlight the unique correlation behavior of structured assets, recognizing the underlying collateral often contains a large diversified pool of issuers. The diversified idiosyncratic risk often results in observed, higher level of correlations for structured assets when compared to, say, corporate credit of similar rating (Yahalom, Levy, & Kaplin, 2010).

Thus, our recommendation for additional analysis to assess the materiality of abstracting from cross-industry and cross-asset class differentiation.

5.3 Maturity Effect on Capital Factors

5.3.1 Summary of Moody’s Analytics Significant Areas of Review and Recommendations

The C1 factors do not differentiate risk across maturity. This can create a material distorted incentive to hold longer-dated bonds whose credit risk is more sensitive to the credit environment. Moody’s recommends exploring a maturity adjustment to the C1 factors.

27 For details, see (Moody’s Analytics, 2012), (Moody’s Analytics, 2020), and references therein.
5.3.2 Review and Analysis Performed by Moody's Analytics

RBC factors are calculated for a ten-year horizon and implicitly assume a maturity of 10 years for all bonds (American Academy of Actuaries, 2015). While the assumption provides simplicity, and the 10-year maturity is recognized as in-line with a modified duration of life insurance portfolios, the sensitivity of risk to maturity is material and can distort the desired composition of asset holdings. There are two aspects to this point:

- **Lifetime loss** — All else equal, including counterparty and recovery, the lifetime loss of a 10-year bond is greater than that of a seven-year or a one-year bond. A flat default probability term-structure would have lifetime loss increasing linearly with time to maturity; the 10-year bond faces roughly 10 times the expected lifetime loss as the one-year bond.

- **Correlated losses** — All else equal, including the expected default probability to maturity, default correlation across two counterparties will be lower if the maturity of one is shorter than the other. Events will impact the longer-dated bond after the maturity of the shorter-dated bond. To further intuit this dynamic, consider the extreme case of a consol bond with no maturity date and a one-year bond to the same counterparty. The events that lead to a default on the consol bond are likely to materialize well after the one-year bond matures.

With these observations, it is clear the proposed RBC factors should consider instrument-level maturity. It is worth exploring the assumptions along with the dynamics that are desired to be captured by the model. If the model is intended to measure capital over a 10-year horizon that includes future investments, assuming matured assets are rolled over, there is some (flawed) justification for treating all bonds as having a 10-year maturity. If, say, the one-year bond is rolled over for 10 years with the same counterparty, its lifetime loss will equate to that of the 10-year bond. Let's explore the two sources of maturity effects listed above:

- **Lifetime loss** — In general, insurance companies invest in high-quality credit, generally facing upward sloping default probability term structures; the 10-year default probability can often be many multiples larger than the 1-year default probability. After all, high credit quality names can only deteriorate in credit over time. Thus, the lifetime loss of the 10-year bond will be substantially higher than the lifetime loss of a strategy involving one-year bonds rolled over into high credit quality counterparties. Table 7 presents investment-grade Moody’s idealized cumulative expected default rates.28 For AAA, the one-year spot default rate is 0.0001%, while the 10-year spot rate is 0.0018% ((0.0100% - 0.0082%)/(1-0.0082%)), almost 20 times larger.

- **Correlated losses** — The issue outlined above continues to prevail. Default correlations will be lower across two counterparties if the maturity of one bond is shorter than that of the other.

With these observations in mind, we suggest exploring a maturity adjustment similar in spirit to the one found in regulatory capital guidelines for banks put forth by the Bank of International Settlements and described in (Basel Committee on Banking Supervision, 2005).

5.4 Investment Income Offsets

5.4.1 Summary of Moody's Analytics Significant Areas of Review and Recommendations

While investment income can be used to offset loss and support statutory surplus, the C1 factors are modeled with the implicit assumption that all investment profits are fully distributed to policyholders or used to absorb product or operational losses. This introduces a potential bias in differentiating investment income across assets, across rating categories, and across asset classes. Accounting for such heterogeneity in investment income can potentially lead to substantial differences in RBC factors across ratings and asset classes. Moody’s recommends more accurately differentiating investment income across assets in the C1 factors.

5.4.2 Review and Analysis Performed by Moody’s Analytics

C1 factors are intended to capture the minimum capital amount that protects statutory surplus from the fluctuations that reduce statutory surplus. While investment income can be used to offset loss and support statutory surplus, it is not explicitly modeled in the current framework under the implicit assumption that all investment profits are fully distributed to policyholders or used to absorb product or operational losses.29

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28 For a detailed discussion of Idealized Default Rates and their use, see (Moody’s Investors Service, 2020 [1]).

29 There are two exceptions: the investment income generated by the Risk Premium portion of the fund (assumed to be 5%) and the risk-free income on capital included in the model.
This introduces a potential bias in differentiating investment income across assets, across rating categories, and across asset classes. Accounting for such heterogeneity in investment income can potentially lead to substantial differences in RBC factor across ratings and asset classes.

Per the [American Academy of Actuaries, 2015], the current C1 factors were last analyzed in 2002. While the methodology was changed, no changes were made to the original C1 factors first reported in 1994 as a result of this 2002 analysis. Since 1994, there has been a wide range of developments in the credit securities markets, and the sorts of credit that insurance companies are exposed to. Specifically, with the prevalence of increasingly complex credit securities, the relevance and variation in interest income have increased. In some cases, interest income plays a material role in the risk profile of a credit security that is not well approximated through the Risk Premium method. For example, according to [Wells Fargo Securities, 2020], structured instruments offer higher interest income compared to corporate bonds of the same rating. As of October 2020, the average investment-grade corporate bond OAS was 122bps, while the average CLO OAS for different investment-grade ratings ranged from 138-415bps, and the average non-agency CMBS OAS for different investment-grade ratings ranged from 103-892bps.

Moody’s recommends more accurately differentiating investment income across assets in the C1 factors.

### 5.5 Comparability Across NRSROs Ratings

#### 5.5.1 Summary of Moody’s Analytics Significant Areas of Review and Recommendations

The model is developed based on Moody’s ratings only. However, NAIC rating designations are typically determined by a set of NRSROs ratings. NRSROs have unique differences in credit rating methodologies and do not provide correspondence because they base their credit ratings on a range of qualitative, as well as quantitative, factors. This creates a challenge when mapping ratings across NRSROs to the various NAIC rating designations. It is plausible that the properties (such as default rate, recovery, etc.) of the NAIC rating in practice are substantially different from those of Moody’s rating used in the model development. With this in mind, we recommend an assessment of variation across NRSROs rating migration, default, and recovery rates, and across the credit cycle. If this is not possible because of, say, lack of historical data, Moody’s Analytics recommends revisiting the use of the second-lowest NRSROs rating in assigning the NAIC designation.

#### 5.5.2 Review Performed by Moody’s Analytics

The Credit Rating Agency Reform Act (CRARA) of 2006 requires that entities that meet defined criteria register with the SEC as a condition of being designated as NRSROs. As a result, as of the beginning of 2019, there were ten rating agencies certified as NRSROs by the SEC. The NAIC adopted the Filing Exempt (FE) rule, granting any NRSRO that has registered with the SEC and has been designated an NRSRO the right to apply and provide credit rating services to the NAIC. Per [National Association of Insurance Commissioners, 2017] the NAIC SVO provides equivalent NAIC designation for nine NRSROs. Per [National Association of Insurance Commissioners, 2007] the FE process will calculate the second-lowest NRSROs rating in assigning the NAIC designation.

The use of multiple NRSROs in the context of model development requires a quantitative correspondence between credit ratings and a range of migration, default probabilities, and loss expectations, that needs to be better understood, recognizing NRSROs assess different aspects of credit risk. For example, Standard & Poor’s recognizes that when, "assess[ing] the creditworthiness of an issuer, S&P Global Ratings evaluates the issuer’s ability and willingness to repay its obligations in accordance with the terms of those obligations... Credit rating agencies may also assess recovery, which is the likelihood that investors will recoup the unpaid portion of their principal in the event of default. Some agencies incorporate recovery as a rating factor in evaluating the credit quality of an issue, particularly in the case of non-investment-grade debt. Other agencies, such as S&P Global Ratings, issue recovery ratings in addition to rating specific debt issues. S&P Global Ratings may also consider recovery ratings in adjusting the credit rating of a debt issue up or down in relation to the credit rating assigned to the issuer (Standard & Poor’s, 2019)." Meanwhile, Moody’s Investor Service, the rating agency arm of Moody’s, takes the position that its “… ratings reflect both the likelihood of a default and the expected loss suffered in the event of default. Ratings are assigned based on a rating committee’s assessment of a security’s expected loss rate (default probability multiplied by expected loss severity)” (Moody’s Investors Service, 2020 (3)).

The Dodd-Frank Act required the SEC to review the feasibility and desirability of NRSROs credit rating standardization, including quantitative correspondence between credit ratings and a range of default probabilities and loss expectations under standardized conditions of economic stress. In their report to congress, [Securities and Exchange Commission, 2012], the Commission recognized the number and uniqueness of rating scales and differences in credit rating methodologies used by credit rating agencies, and that NRSROs do not provide such a correspondence, because they base their credit ratings on a range of qualitative, as well as
quantitative factors. With this in mind, we recommend an assessment of variation across NRSROs rating migration, default, and recovery rates, and across the credit cycle. If this is not possible because of, say, lack of historical data, Moody’s Analytics recommends revisiting the use of the second-lowest NRSROs rating in assigning the NAIC designation.

5.6 Climate Hazards and Emerging Risks

5.6.1 Summary of Moody’s Analytics Significant Areas of Review and Recommendations

The C1 factors do not explicitly consider climate hazards or emerging risks (e.g., pandemic or cyber). These risks may not be explicitly incorporated into NRSRO ratings and may not be reflected in the historical data used in estimating the C1 factors. While climate hazards are particularly relevant for the likes of real estate and municipal credit, growing evidence suggests climate hazards and other emerging risks can be material for corporate credit. Moody’s Analytics recommends exploring the potential impact of climate hazards and emerging risks on C1 factors across asset classes.

5.6.2 Review Performed by Moody’s Analytics

Climate hazards and emerging risks are drawing growing concerns from credit investors, financial regulators, and rating agencies. COVID-19 has demonstrated the rapid and cascading impacts of a global catastrophic risk that may not be explicitly considered in the NRSRO ratings and that may not be reflected in historical data. Pandemics — as well as climate hazards, debt crises, cyberattacks, and other events — are high-likelihood, high-impact risks (World Economic Forum, 2021).

Climate hazards have been recognized to impact municipal and commercial real estate credit. Climate hazards can be categorized into chronic and acute hazards. The impacts of the acute climate hazards, typically low-frequency and high-damage, may be worth special attention. Hurricane Harvey, for example, had Moody’s downgrade Port Authority (Steinberg, 2018). Climate hazards are increasingly recognized as a risk for longer-dated corporate credit (Levy & Freitas, 2019). One study finds that eighteen sectors with $7.2 trillion issues have high inherent exposure to physical climate risks (Moody’s Investors Service, 2020 (4)). The largest sectors in terms of rated debt include emerging market governments, regulated electric and gas utilities with generation, and integrated oil and gas companies. Moody’s Investors Service has put efforts to include environment, social, and governance (ESG) risk assessment in the rating issuance and monitoring process. Moody’s Investors Service launched a specialized ESG analytical team in March 2017 and published General Principles for Assessing Environment, Social and Governance Risks in January 2019. ESG factors were cited in half of public-sector rating actions taken in the 15 months through the first quarter of 2020 (Moody’s Investors Service, 2020 (5)). Likewise, S&P and Fitch have also been incorporating the ESG considerations into their ratings methodologies. For S&P, environmental and climate (E&C) concerns affected corporate ratings in 717 cases, or approximately 10% of corporate ratings assessments and resulted in a rating impact (an upgrade, downgrade, outlook revision, or CreditWatch placement) in 106 cases between July 2015 and August 2017 (S&P Global Ratings, 2017). Fitch Ratings developed an integrated scoring system, ESG Relevance Scores, which clearly displays how ESG factors impact individual rating decisions (Fitch Ratings, 2020).

Many regulators have been increasingly recognizing these risks. The European Central Bank (ECB), for example, speaks to “the number of catastrophes caused by natural hazards… Adjusting for inflation, overall economic losses… of USD 350 billion in 2018” (Lagarde, 2020). Governor Lael Brainard of the Federal Reserve speaks “we are already seeing elevated financial losses associated with… the frequency and intensity of extreme weather events” and cites the example of climate-related bankruptcy of Pacific Gas & Electric. She also points out “mortgages in coastal areas are vulnerable to hurricanes…” (Brainard, 2020). “Extreme weather…” is highlighted as one of the highest impact risks of the next decade in the Global Risks Report (World Economic Forum, 2020).

While being increasingly important considerations in NRSRO ratings, climate hazards and emerging risks may not be explicitly incorporated into historical NRSRO ratings nor reflected in the historical data used in estimating C1 factors. Moody’s Analytics recommends exploring the potential impact of climate hazards and emerging risks on C1 factors across asset classes.

30 See Moody’s Analytics Research Paper for an empirical assessment of financial impacts of climate-related hazard events (Cukanoglu, Milonas, Zhao, & Brizhatyuk, 2020)
31 Other factors such as changes in economic growth, budget deficits or leverage metrics are also considered. When a rating action cites an ESG issue as a material credit consideration, it does not necessarily mean that the issue was a key driver of the rating action.
6  Suggested Next Steps

As discussed in the Executive Summary, this report documents Moody’s Analytics objective assessment of the modeling process, the development of assumptions from underlying experience, and the adjustments to reflect diversification of individual company portfolios used in investment risk factors for fixed income assets. The report recognizes that C1 factors have potential implications for business decisions that can ultimately impact solvency. Moreover, Moody’s Analytics is aware of the significant effort involved in a broader redesign of C1 factors and understands the original scope was limited to model parameter updates and increased C1 factor granularity in the C1 Factor Proposal. Moody’s Analytics appreciates that since the original C1 factors were released in 1992, life insurance exposure to credit has increased in size and complexity, and that new data and techniques are now available that can better describe credit risk.

With these aspects in mind, we suggest a phased-in approach, whereby, targeted aspects of the model development are addressed immediately, recognizing that a broader redesign of C1 factors is also in order. Both the immediate changes, as well as the broader redesign, should have stakeholders prioritize items from Table 1, Table 2, and Table 3, along with potential items outside the scope of this report, recognizing that: (1) changing only one aspect must be done cautiously, given the interconnectedness of portfolio models, and that (2) the objective of allowing C1 factors and their impact on business decisions is to align with prudential management of solvency.

As discussed, the tight April deadline limits the possible items that can be revised during the first phase, focusing on the “slope” of charges across credit ratings and the portfolio adjustment function. The revisions should be approached in conjunction with stakeholders iteratively, as follows:

- Review and prioritize modifications to the proposed rules, along with the current rules as a point of reference.
- Assess and agree on performance criteria, along with possible data sources and methodologies.
- Propose updated model parameters and C1 factors, recognizing benchmarking and validation concerns including model limitations, and adhering to sound model risk management guidelines (Board of Governors of the Federal Reserve System and Office of the Comptroller of the Currency, 2011).
- Assess implications for solvency across the life insurance industry.

In addition, Phase 1 should include an articulation of model limitations related to the other items referenced in this document at a level of detail and adhering to a timeline to be determined jointly with stakeholders.

The Phase 2 broader redesign should start as soon as practical, prior to completion of Phase 1. It would not be completed in 2021, recognizing the lead time needed for data collection and research. It should be approached in conjunction with stakeholders in an iterative manner, as follows:

- Obtain clarity on the desired level of:
  - Model complexity (e.g., issuer concentration)
  - Granularity (e.g., differentiating across asset risks)
- Assess cost implications
  - Resources, including personnel, to develop and implement models within a sound model risk management framework
  - Data collection
  - Model monitoring and model re-development
- Articulate governance — potentially impacting organizational structure at insurance companies and NAIC
  - Control mechanisms through policies and procedures associated with model development, validation, implementation, and use
- Propose redesigned C1 factors
  - Assess and agree on performance criteria, along with possible data sources and methodologies
  - Propose updated model and C1 factors, recognizing benchmarking and validation concerns, including model limitations, and adhering to sound model risk management guidelines (Board of Governors of the Federal Reserve System and Office of the Comptroller of the Currency, 2011)
  - Assess implications for solvency across the life insurance industry
References


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registered with the Japan Financial Services Agency and their registration numbers are FSA Commissioner (Ratings) No. 2 and 3 respectively.

Recognized Statistical Rating Organization ("NRSRO"). Therefore, credit ratings assigned by MSFJ are Non-NRSRO Credit Ratings. Non-NRSRO Credit Ratings are assigned by an entity that is not a NRSRO and, consequently, the rated obligation will not qualify for certain types of treatment under U.S. laws. MJKK and MSFJ are credit rating agencies that are registered with the Japan Financial Services Agency and their registration numbers are FSA Commissioner (Ratings) No. 2 and 3 respectively.

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Assessment of Proposed Revisions to the RBC C1 Bond Factors
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Moody’s Investors Service (MIS) provides investors with a comprehensive view of global debt markets through credit ratings and research. Moody's Analytics provides data, analytics, and insights to equip leaders of financial, non-financial, and government organizations with effective tools to understand a range of risks.

Throughout this document, “Moody’s” rating refers to an MIS rating. And while references to MIS are made, the views and opinions in this document are solely of Moody’s Analytics.
Agenda

1. Project Overview
2. Key Findings
3. Recommended Next Steps

Appendix I. Detailed Phase 1 Scope
Appendix II. Detailed Significant Areas of Review and Recommendations
Project Overview
Background

Timeline

» On October 22, 2020, the ACLI, in conjunction with the NAIC, put forth a public RFP to assess the proposed RBC C1 Bond Factors.
» On December 4, 2020 Moody’s Analytics was awarded the RFP.
» Moody’s Analytics delivered the final report and recommendations for public comment on February 1, 2021.

Why Moody’s Analytics?

» Objective reputation
» Credit portfolio risk thought leader;
   RiskFrontier used by 9 of 12 largest North American life insurers for tail risk
» Comprehensive and granular asset correlations, built using decades of data and default risk experience
» Proprietary default datasets, across multiple asset classes, that can be used to inform our analysis
» Fixed income market data, sourced from multiple authorities, including Moody’s Investors Service, with access to underlying data across asset classes, including Corporates, Municipals, Structured, and CRE
» Decades of experience with regulatory initiatives, including IFRS 17, CECL, IFRS 9, Basel, CCAR.
» Experience directly supporting regulators in defining capital guidelines
RFP Requirements

Assess the proposed required capital factors for the default risk on bonds.
Review the proposed revisions to the RBC C-1 bond capital factors, including supporting documentation of the development of assumptions and modeling process, and stakeholder feedback on the proposed revisions, focused on concerns with the modeling process, the development of assumptions from underlying experience, and the adjustments to reflect diversification of individual company portfolios.

Moody’s Analytics objective opinion based on access to supporting documentation and stakeholder feedback, including the NAIC, ACLI and its members

Practical recommendations

» Quantifying identified risks intended to be captured by C1 factors
» Using data and modeling approaches recognized as best practice and that meet financial industry standards (documentation, model validation, back-testing, performance benchmarking…)
» Acknowledging impact on business decisions through regulatory capital arbitrage incentives, shifting asset holdings, effecting solvency, macroprudential resiliency, and capital markets
Proposed C1 Factors: Context

The Academy's Defined Scope was dictated by the NAIC RBC Working Group and limited to:

» Updated data
» Expansion to 20 designations
» Maintaining the modeling structure designed ~30 years ago (cutting edge for the early 90s)

The report is not limited to the Defined Scope, rather it takes a broader view, recognizing:

» Modeling techniques and data availability have evolved with capital markets (e.g., structured assets)
» Life insurance asset holdings have changed along with capital markets
Key Findings

2
Proposed C1 Factors: Areas of Concern

Not using best practice with data and modeling choices
» This includes items within the Defined Scope, as well as items outside of the Defined Scope, that Moody’s feels are relevant and material.

Model documentation, does not generally meet financial industry standards. Critical for ongoing model monitoring and model updates. With limited articulation of model limitations, the potential for distorted business use has implications for solvency.
» Incomplete documentation
» Incomplete model validation, back-testing, and performance benchmarking
» Incomplete articulation of model limitations
**Modeling and Data Concerns Within Defined Scope**

Methodologies used in estimating default rates and recovery rates do not lend themselves to statistical properties of the data, including:

- Appropriately capturing the risks across ratings when applying the methodology across the granular 20 designations, considering limited data availability and the statistical properties of ratings and default.
- Calibration of the portfolio adjustment function to accurately capture the benefits of diversification. The current proposal may be overly punitive to holdings of smaller life insurance companies. The rational for doubling of C1 factors of the 10 largest issuers is also unclear.

**Overly conservative assumption for the risk premium**

- Inputs for which accurate proxies are available, as in the case with the risk premium, should be directly used to facilitate transparency and avoid inadvertent risk shifting across categories. Conservatism can be added in the final stage (i.e., when setting percentile loss).

**Dated discount rate and tax assumptions**
Modeling and Data Concerns Outside the Defined Scope

Lack of differentiation across asset classes (e.g., corporate, structured, municipal credit), maturity, and investment income offsets

» Rating agencies recognize that the fundamental risk drivers differ across asset classes.

» The report finds material differences in observed default, migration, and recovery dynamics across asset classes.

The use of multiple NRSROs given their potential lack of comparability

» NRSROs have unique differences in credit rating methodologies and do not provide correspondence, because they base their credit ratings on a range of qualitative, as well as quantitative, factors.

The economic state modeling framework does not lend itself to statistical properties of default and recovery dynamics

Lack of consideration for climate hazards or emerging risks (e.g., pandemic or cyber)

» These risks may not be explicitly incorporated into NRSRO ratings and may not be reflected in the historical data used in estimating the C1 factors.
Recommended Next Steps
A Phased-In Approach is Recommended

**Phase 1: Moody’s to Propose C1 Factors**

Delivered to the LRBCWG and exposed on or before April 30 for comment

Final factors to be approved by both LRBCWG and CADTF by June 30

*Model development within Defined Scope and aligning with current Official NAIC Annual Statement Blank*

Consensus-driven approach on methodologies and data across the NAIC, ACLI and its members. Documentation includes model validation and limitations that meet financial industry standards.

**Phase 2: Long-term partnership through 2022+**

*Modeling and data updates outside the Defined Scope*, providing NAIC data and tools to better understand and articulate life insurance companies’ credit portfolio risks, recognizing range of holdings have changed materially since C1 factors were introduced.

» **Broader model development**, including cross-asset class differentiation, prioritized with stakeholders, with methodologies and data that meet financial industry standards.

» **Overall model documentation**, that meets financial industry standards, in particular covering elements of the model not modified in Phase 1.

» **Data consortium**, covering private placements and possibly other asset classes.
Phase 1 Timeline
Scope defined jointly with stakeholders while recognizing timeline constraints

By March 31
- V1 proposed factors, iterating with NAIC and ACLI
  - Consensus on methodology, data, and performance criteria
  - Consensus on target probability
- V1 light documentation
- V1 initial industry impact analysis

By April 30
- Delivered to the LRBCWG and exposed for comment
- Initial documentation and validation
- Impact analysis, iterating with NAIC and ACLI
  - Consensus on methodology, data, and limitations
  - Consensus on target probability
- Initial focus group discussions and training

By June 30 (Iterating with NAIC/ACLI as needed)
- Final factors to be approved by both LRBCWG and CADTF
- Final documentation and validation of factors that meet financial industry standards
- Final focus group discussions and training
Phase 2 Broader Model Development

Approached in conjunction with stakeholders iteratively

**Obtain clarity** on the desired level of:
- Model complexity (e.g., issuer concentration)
- Granularity (e.g., differentiating across asset risks)

**Assess cost implications**
- Resources, including personnel, to develop and implement models
- Data collection
- Articulate governance — potentially impacting organizational structure at insurance companies and NAIC

**Propose redesigned C1 factors**
- Assess and agree on performance criteria, along with possible data sources and methodologies
- Propose updated model, and C1 factors that meet financial industry standards
- Assess implications for solvency across the life insurance industry
Appendix I

Detailed Phase 1 Scope
Phase 1: Final scope to be agreed on by stakeholders

**Base factors**

- Risk Premium: Use 1 standard deviation loss (rather than mean)
- Updated discount and tax rate assumptions
- PD and LGDs
  - Use Idealized Default Rates
  - Re-estimate LGD with date errors fixed
  - Fix LGD error in economic state model
  - Limitation - economic state scalar would remain unchanged
- Obtain a representative set of corporate bond holdings and ratings across life insurance companies
- OPTIONAL - Portfolio construction requires an additional [uncertainty has no guarantee of delivery for Phase 1, but will be usable for Phase 2]
  - Explore alternative portfolio construction methods
- Iterate with NAIC on target probability to ensure “average” level, in-line with NAIC risk tolerance
- Iterate with industry on slope and impact

**Portfolio adjustment Function**

- Integrate the doubling of 10 largest holdings requirement with portfolio adjustment function
- Explore alternative regression approaches such as equal weighted error minimization rather than dollar weighted, to allow for better description for small insurance companies
- Assessment of concentration risk using Moody’s Analytics internal benchmarks, which would be made public
- Iterate with NAIC on target probability to ensure “average” level, in-line with NAIC risk tolerance
- Iterate with industry on impact
Appendix II

Detailed Significant Areas of Review and Recommendations
# Review of Key Inputs

Summary of significant areas of review and recommendations

| Default Rates | The methodologies used by the C1 Factor Proposal to construct default rates across ratings, as well as methodologies used in differentiating default rates across expansion and contraction states, face data limitation challenges. Moody’s Analytics recommends updating the methodologies and using additional data referenced in the review that have been demonstrated to better capture credit dynamics. |
| Recovery Rates | The C1 Factor Proposal’s method used to recognize the recovery date does not align with the date of default. This deviation can result in bias with recovery rate levels, as well as their relationships with default rates. Moody’s Analytics recommends exploring the use of more accurate data and groups when describing recovery distributions and utilizing more current techniques that link recovery with the credit environment. |
| Discount Rate | Since the modeling work was conducted by Academy in 2015, the discount rate used in the model is calculated using historic data that does not reflect the current low-interest environment, nor the expected continuation of a low interest rate environment. Moody’s Analytics recommends updating the discount rate to include December 31, 2013 – December 31, 2020 data to better reflect the current and expected interest rate environment, in conjunction with updated tax assumptions that reflect the 2017 Tax Act. |
| Construction of the Representative Portfolio | The segmentation and filtering of the sample portfolios used to construct the representative portfolio lack economic justification or sensitivity analysis. For example, for reasons not explained, only NAIC1 and NAIC2 rated issuers are used to determine the number of bonds in the representative portfolio for all rating categories. In addition, each representative portfolio ultimately used in the simulation contains one rating category, which makes the final C1 factors heavily dependent on portfolio adjustment factors. Given the importance of the representative portfolio, we recommend more comprehensive documentation and robustness tests that can show whether the segmentation and filtering method has material impact on the C1 factors and explore the option of constructing a representative portfolio that contains all rating categories. |
| Tax Assumptions | The U.S. corporate tax rate was lowered from 35% to 21% in accordance with the 2017 Tax Reconciliation Act (Deloitte, 2018). Net capital gains included in the taxable income are subject to the 21% rule (CCH Group, 2019). While the model was developed based on historical data before the tax cut, the RBC factors, if adopted, will be applied to insurers, which will pay the updated tax rate. It will be worthy to consider updating the assumed 35% tax rate to 21%. Moody’s Analytics recommends analysis reflecting the current tax environment. |
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Assessment of the Proposed Revisions to the RBC C1 Bond Factors, February 2021

The current assumption of setting the Risk Premium equal to expected loss appears to be overly conservative. While the C1 Fac tor
Proposal recognizes the inconsistency, they point out that the 1992 guidelines defined the Risk Premium in this way and, in
conjunction with other parameters, some of which (e.g., AVR) are beyond the scope of this report. While Moody’s Analytics
appreciates the desire to incorporate conservativeness into assumptions, inputs for which accurate proxies are available shou ld be
directly used, and rather incorporate the conservative overlay into the final steps to facilitate model transparency. Moody’s Analytics
recommends a broader evaluation of the various interconnected modeling decisions that lead to setting the Risk Premium at the
expected loss level, and aligning the models with a general consensus across the actuarial community, including setting the R isk
Premium at a one standard deviation loss.

The portfolio adjustment factor is one of the most important elements of the model, as it ultimately determines the general R BC level
for individual insurers. Unfortunately, documentation is limited, making it difficult to access the materiality of some of th e modeling
choices. In addition, the limited documentation available suggests a potential material gap between the calculated C1 factor and its
target level for individual insurers, especially smaller ones. Moody’s Analytics recommends: (1) more detailed documentation of the
adjustment factor and the underlying economic justification, in conjunction with the doubling of C1 factors for the top -10 largest
issuers; (2) further exploring the data and methods used to estimate the portfolio adjustment factors, to ensure they are eff ective for
corporate as well as non-corporate issuers, (3) design the factors to align incentives with the economic risks, and (4) design a
structure that brings together the portfolio adjustment factors along with the doubling of C1 of the 10 largest issuers.

Portfolio
Adjustment
Factors

Risk Premium

We have three main concerns regarding the economic state model, which are closely related to the discussion in Section 3.1. F irst,
the two-state model does not accurately capture persistency in default and recovery rates across the credit cycle. Second, the
economic state of Loss Given Default (LGD) appears to be mistakenly disconnected from that of default rate for ratings Baa -Caa.
Third, the scaling factor used in differentiating default rates across expansions and contractions appears to be overly punit ive for the
investment-grade segment compared with historical patterns. Moody’s Analytics recommends a more holistic review of the choice of a
framework that can address broader sets of issues, including more precise differentiation across asset classes, as discussed in other
sections.

Economic State
Model

Summary of significant areas of review and recommendations

Review of Model Framework

20

10-684
NAIC Proceedings – Spring 2021
Attachment Three-B2
Capital Adequacy (E) Task Force
3/23/21


Review of Elements Outside of the Defined Scope

Summary of significant areas of review and recommendations

<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applicability of Moody’s Rated Corporate Data to Other Asset Classes</strong></td>
<td>C1 RBC base factors were developed using Moody’s default rate data on Moody’s rated public corporate bonds (this report, as well as references herein, uses public corporate and Moody’s rated corporate interchangeably) supplemented with S&amp;P’s recovery data. After controlling for ratings, we find material differences in observed default, migration, and recovery dynamics across asset classes. These differences question the effectiveness of using public corporate bond data for all asset classes. Moody’s Analytics recommends evaluating the possibility of estimating distinct C1 factors using asset-class specific data. For private placements, in particular, Moody’s Analytics recommends exploring a centralized collection of default, migration, and recovery data that can later be used in further estimating distinct C1 factors and for other purposes.</td>
</tr>
<tr>
<td><strong>Simulation and Correlation</strong></td>
<td>The current C1 factor model does not account for variation in cross-industry and cross-asset class concentration risks nor diversification that may be different across life companies' portfolios. These variations can be material, and we recommend additional analysis that assesses the materiality of abstracting from cross-industry and cross-asset class diversification.</td>
</tr>
<tr>
<td><strong>Maturity Effect on Capital Factors</strong></td>
<td>The C1 factors do not differentiate risk across maturity. This can create a material distorted incentive to hold longer-dated bonds whose credit risk is more sensitive to the credit environment. Moody’s Analytics recommends exploring a maturity adjustment to the C1 factors.</td>
</tr>
<tr>
<td><strong>Investment Income Offsets</strong></td>
<td>While investment income can be used to offset loss and support statutory surplus, the C1 factors are modeled with the implicit assumption that all investment profits are fully distributed to policyholders or used to absorb product or operational losses. This introduces a potential bias in differentiating investment income across assets, across rating categories, and across asset classes. Accounting for such heterogeneity in investment income can potentially lead to substantial differences in RBC factors across ratings and asset classes. Moody's Analytics recommends more accurately differentiating investment income across assets in the C1 factors.</td>
</tr>
<tr>
<td><strong>Comparability Across NRSROs</strong></td>
<td>The model is developed using Moody’s rating only. However, NAIC rating designations are often determined by a set of NRSROs ratings. NRSROs have unique differences in credit rating methodologies and do not provide correspondence because they base their credit ratings on a range of qualitative, as well as quantitative, factors. This creates a challenge when mapping ratings across NRSROs to the various NAIC rating designations. It is plausible that the properties (such as default rate, recovery, etc.) of the NAIC rating in practice are substantially different from those of Moody’s rating used in the model development. With this in mind, we recommend an assessment of variation across NRSROs rating migration, default, and recovery rates, and across the credit cycle. If this is not possible because of, say, lack of historical data, Moody’s Analytics recommends revisiting the use of the second-lowest NRSROs rating in assigning the NAIC designation.</td>
</tr>
<tr>
<td><strong>Climate Hazards and Emerging Risks</strong></td>
<td>The C1 factors do not explicitly consider climate hazards or emerging risks (e.g., pandemic or cyber). These risks may not be explicitly incorporated into NRSRO ratings and may not be reflected in the historical data used in estimating the C1 factors. While climate hazards are particularly relevant for the likes of real estate and municipal credit, growing evidence suggests climate hazards and other emerging risks can be material for corporate credit. Moody’s Analytics recommends exploring the potential impact of climate hazards and emerging risks on C1 factors across asset classes.</td>
</tr>
</tbody>
</table>
MOODY'S ANALYTICS
Assessment of the Proposed Revisions to the RBC C1 Bond Factors, February 2021

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Bahn Capital Adequacy (E) Task Force
Attachment Three B2
532321
January 29, 2021

Philip A. Barlow, FSA, MAAA
Chair, Life Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Re-alignment of RBC Guidance and INT 20-03 Modification Dates

Dear Mr. Barlow and Working Group Members:

The Mortgage Bankers Association and the American Council of Life Insurers respectfully recommend that the Life Risk-Based Capital Working Group (LRBCWG) modify its Additional Guidance on the Financial Condition (E) Committee’s Guidance for Troubled Debt Restructurings (RBC Guidance) to align the modification period with revised INT 20-03, Restructuring Due to COVID-19.

Troubled debt restructurings (TDR) relief under both the RBC Guidance and INT 20-03 was issued in furtherance of the E Committee’s statement of support for “the use of prudent loan modifications that can mitigate the impact of COVID-19.” Accordingly, the E Committee, Statutory Accounting

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1 The Mortgage Bankers Association (MBA) is the national association representing the real estate finance industry, an industry that employs more than 280,000 people in virtually every community in the country. Its membership of over 2,300 companies includes all elements of real estate finance: mortgage companies, mortgage brokers, commercial banks, credit unions, thrifts, REITs, Wall Street conduits, 70 life insurance companies engaged in real estate finance, and others in the mortgage lending field. For additional information, visit MBA’s website: www.mba.org.

2 The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 95 percent of industry assets in the United States. Learn more at www.acli.com.

3 See RBC Guidance, p. 1 ("This guidance is being issued by the Financial Condition (E) Committee to all U.S. insurers filing with the NAIC in an effort to encourage insurers to work with borrowers who are unable, or may become unable to meet their contractual payment obligations because of the effects of COVID-19. The Committee, which is the NAIC parent committee of all the solvency policy making task forces and working groups of the NAIC, supports the use of prudent loan modifications that can mitigate the impact of COVID-...")
Principles Working Group (SAPWG), and LRBCWG have taken actions necessary to align the RBC Guidance and INT 20-03 modification periods for the reporting periods ending June 30, September 30, and December 31, 2020.

On January 25, 2021, SAPWG revised the modification period under INT 20-03 to conform to the TDR provision of the CARES Act, as amended by the Consolidated Appropriations Act, 2021, which was signed into law on December 27, 2020. As a result, INT 20-03 now applies to modifications that occur during “the period ending on the earlier of January 1, 2022 or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID–19), outbreak declared by the President on March 13, 2020 under the National Emergencies Act terminates.” In contrast, the modification period under the RBC Guidance ended December 31, 2020.

To re-align modification periods under RBC Guidance with INT 20-03, we recommend that the LRBCWG revise its Additional Guidance dated October 9, 2020, as follows:

**Origination Date, Valuation Date, Property Value, and 90 Days Past Due**

For purposes of the Description/explanation of item in the Risk-Based Capital Reporting Instructions for Date of Origination (2), Property Value (20), Year of Valuation (21 and by reference Quarter of Valuation - 22), and 90 Days Past Due? (29), no changes to these values are required for any COVID-19 related modifications that occur during the period ending on the earlier of January 1, 2022 or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID–19), outbreak declared by the President on March 13, 2020 under the National Emergencies Act terminates. This guidance is consistent with the Financial Condition (E) Committee Guidance for Troubled Debt Restructurings for March 31 - September 30 Statutory Financial Statements and Related Interim Risk-Based Capital Filings (where required) (June 12, 2020) and Question and Answer issued by the NAIC but extended for COVID19 modifications that occur through the end of the period described above.

To facilitate insurer’s planning and reporting activity, we urge LRBCWG to make such a revision as early as possible during the reporting period ending March 31, 2021.

Respectfully,

Mike Flood  Paul S. Graham, III

Attachment: INT 20-03. Troubled Debt Restructuring Due to COVID-19 (revised January 25, 2021)

cc: Dave Fleming, NAIC Senior Insurance Reporting Analyst

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19.”); see also INT 20-03, p. 1, INT 20-03 Issue, para. 3 (citing the same language as part of the SAPWG rational for issuing INT 20-03).
Life Risk-Based Capital (E) Working Group
Virtual Meeting
January 21, 2021

The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Jan. 21, 2021. The following Working Group members participated: Philip Barlow, Chair (DC); Steve Ostlund (AL); Thomas Reedy (CA); Deborah Batista (CO); Wanchin Chou (CT); Sean Collins (FL); Vincent Tsang (IL); Mike Yanacheak (IA); John Robinson (MN); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner (TX); and Tomasz Serbinowski (UT).

1. Exposed the ACLI’s Real Estate Proposal

Mr. Barlow reminded the Working Group that this proposal was originally presented to the Investment Risk-Based Capital (E) Working Group and is now for this Working Group’s consideration. He said work on this was done a few years ago but was delayed while work on the bond proposal was done, and now the goal is to implement this proposal at the same time as the proposal for bonds.

John Bruins (American Council of Life Insurers—ACLI) said he believes the focus of this meeting is to review and, hopefully, expose the structural changes with a more robust discussion of the proposal and the factors during a subsequent meeting. Mr. Barlow concurred.

Mr. Bruins said a brief overview of the proposal was provided during the Dec. 17, 2020, meeting. He said Rich McLemore (MetLife), representing the ACLI, would continue that discussion, but that he would discuss the two parts of the proposal that require structural changes in more detail after that.

Mr. McLemore said the proposed changes are important to industry and that the ACLI’s analysis shows that they are warranted. He said the current methodology unduly limits life insurance companies’ access to a large and important higher returning asset class during today’s low-rate environment when stable and consistent income is already difficult to source. He said the current framework keeps life insurance company capital largely on the sidelines of a market that can provide good portfolio diversification and aid in effective asset-liability management.

The current real estate equity risk-based capital (RBC) framework assesses a 15% base RBC charge on wholly owned directly held real estate investments that are reported on Schedule A, except for foreclosures, and a higher 23% charge on foreclosures and all other real estate investments that are held through fund, joint ventures or other structures and reported on Schedule BA. This framework and charges were implemented years ago at a time when private real estate investment performance history was limited. At that time, the factor was estimated based on an assumed relationship between private real estate and common stocks.

Mr. McLemore said that 30 years ago, the recommendation was for ongoing study, and to date, no subsequent complete study has been done. He said that today, the actual sector performance data depth and history required to assess an appropriate charge more accurately is available, and the appropriate charge is much lower than was originally estimated. He said this is the component of the proposal that recommends lowering the factor applied to real estate.

The current real estate equity risk-based capital (RBC) framework assesses a 15% base RBC charge on wholly owned directly held real estate investments that are reported on Schedule A, except for foreclosures, and a higher 23% charge on foreclosures and all other real estate investments that are held through fund, joint ventures or other structures and reported on Schedule BA. This framework and charges were implemented years ago at a time when private real estate investment performance history was limited. At that time, the factor was estimated based on an assumed relationship between private real estate and common stocks.

Mr. McLemore said that 30 years ago, the recommendation was for ongoing study, and to date, no subsequent complete study has been done. He said that today, the actual sector performance data depth and history required to assess an appropriate charge more accurately is available, and the appropriate charge is much lower than was originally estimated. He said this is the component of the proposal that recommends lowering the factor applied to real estate.

Mr. McLemore said in the original estimation of RBC charges for real estate, a risk premium was assessed on assets that were held in fund, joint venture or other structures, as the lower levels of investment control by the life company, and the overall lower transparency of the investments, was thought to substantially increase the potential risk. He said a subjective 50% premium was assessed in order to account for this perceived increased risk, which brought the factor for these investments up to 23%. He said that today, in many cases, real estate investments can be held in structures mostly to reduce risk.

In the simplest case, Mr. McLemore said one only has to look at limited liability companies, which is a structure implemented almost solely to protect the insurance company from the risks associated with claims at the properties, like accidents or joint ventures, which are often structures used by insurance companies to align interests with local expert investors and managers of real estate investment assets. In the proposal, he said the ACLI is asking for reconsideration of the assumed higher risk level, and higher RBC charge, associated with these Schedule BA real estate assets.
Mr. McLemore said the final key aspect of the proposal is a proposed adjustment to required individual property RBC that will account for the cushion against RBC losses that is often created in real estate assets as they are held over time. He said the RBC factors that exist today, and even the new lower factors that are proposed, are based on market value volatility in our sector. However, he said the real estate assets are reported for statutory accounting using depreciated cost, and each year the asset’s statutory value declines, even though the actual market value of the asset is more likely to be increasing. He said this creates an unrealized gain, and this unrealized gain is, in effect, a cushion that must be completely eroded before there is any risk of loss of statutory capital. He said this is a critically important concept to understand, and the ACLI believes it must be accounted for in an accurate and fair RBC methodology.

With respect to a depreciation cushion, Birny Birnbaum (Center for Economic Justice—CEJ) said that in the aftermath of the savings-and-loan experience, what was seen was some leveraging of loans or buildings that did not add value and that the value of the buildings declined over time with, in some instances, new commercial building from the 1980s until the early 2000s. He asked if the assessment of the depreciation cushion is based on a particular time frame as opposed to a longer time series. He said there are also questions about the value of commercial real estate going forward, with a number of companies moving to work-from-home situations and the resulting demand for office space, along with the number of shopping malls closing. He asked how this longer-term impact is being considered in the proposal.

In terms of the longer-term, Mr. McLemore said the effects of the savings and loan crisis and the global financial crisis are both incorporated in the estimation of the proposed factors. If the concern is that there is going to be a reduction in RBC for assets where the values are falling dramatically and the capital that should be held on these higher leveraged investments could be understated, he said the opposite would be the effect of the implementation of the proposed change because RBC would be allowed to go up beyond the base factor in the case of a situation where the market value was below the depreciated cost. He said those types of environments would be short-lived because that will typically trigger a real estate impairment based on the impairment testing done on an annual basis.

Mr. McLemore said the question on the larger structural changes in the economy about how real estate is held in the future is a good one but is difficult to answer right now. However, he indicated that MetLife’s view is that the impact is going to be more transitory. He said MetLife is seeing an acceleration of pressures that were already in place, as an example in certain segments of the retail market and the long-term sustainability of business models that are going to be more affected by online retailing and e-commerce. For hotels, he said MetLife is less convinced that the impacts are going to be more longer-term but that they will persist over the next couple of years. He said with the introduction of vaccines, the market will return to more of a stabilized demand base to pre-pandemic levels by 2023 or 2024.

Mr. McLemore said the question about office space is probably one of the bigger questions, but MetLife’s research does not see the increasing work-from-home environment having as large a long-term structural change as some might suggest because it is not as effective for companies over a longer period of time as they hire new people and experience turnover. He said MetLife has seen companies that have tried to fully outsource through time, and many of those have made the decision to revert back to a more office-based employment. He said the discussion of how these structural changes should influence the calibration of RBC is a larger question and not restricted to real estate.

Mr. Bruins added that RBC is not structured to look at today’s particular environment and consider that the results over the next year or two might be worse. He said factors are established looking historically at what the variations have been and take into account the worst of what the modeling shows. He said that is what the analysis for this real estate proposal has done.

Mr. Barlow asked if data can be provided that illustrates the impact of how a decline in the market value of a property, and they are marked down as Mr. McLemore indicated, is reflected in the financial statements. Mr. Bruins said the ACLI would work to provide this.

Mr. Tsang said, in general, he agrees with the proposal updating the factor for real estate by looking at the more emerging statistics but expressed concern with the inclusion of unrealized gains and losses in the RBC calculation. He said real estate does not have a deep secondary market like bonds and mortgages, which probably makes the fair value less transparent. He expressed concern with real estate reported on Schedule BA because of the inability to get out of these commitments. He said bonds and mortgages do not have the unrealized gains and losses being reflected in their RBC requirements and questioned why real estate should have this element introduced.

Mr. Bruins said he may partially address Mr. Tsang’s comments while going through the structural changes, but these may need more fuller discussion during future meetings.
Mr. Barlow said that is fine as this proposal is going to require more discussions as these and other questions are addressed. However, he asked Mr. Bruins to address, to the extent possible, flexibility in light of these questions with respect to the final RBC charges based on the structural changes being proposed.

As background, Mr. Bruins said the proposal and all the documents were put together to be a unified proposal even though they are being addressed in pieces, with today’s focus being on the structural changes. As such, all the documents and examples use the factors that are in the proposal, and this is not a presumption that these will be the final factors but a matter of consistency in the presentation. Thus, he asked Working Group members to focus on what the formulas and relationships are. He said real estate is an equity asset but is held in statutory accounting at book value, which is a depreciated cost. RBC looks at the risk of loss of statutory capital, which is based on the statutory value. If the market value is greater than the depreciated cost, Mr. Bruins said this has no effect on the statutory values, unless it gets to the point where the market value is less than the statutory value and there is a need to review for impairment. As long as the market value is above the statutory value, he said it will never affect the statutory value.

Mr. Bruins said this is where the margin Mr. McLemore alluded to comes in. He said the proposal is to recognize two-thirds of that margin and to reduce the factor proportionally on a property-by-property basis. With regard to Mr. Barlow’s question on flexibility, this would be something that could be changed easily if done as a factor input.

To Mr. Tsang’s point, Mr. McLemore said there is some uncertainty because real estate values are not valued on a daily basis, and two-thirds is in the proposal as opposed to a 100% offset to address that concern.

Mr. Bruins discussed the examples as included on Page 5 of the ACLI’s presentation (Attachment Three-C1). The other area of structural change is for encumbrances as included on Page 6 of the presentation. Mr. Bruins said this is simply a redesign of the calculation, which does not affect the final result as explained and illustrated on the next two pages of the presentation. Rather, it facilitates for the inclusion of the excess of market value over book value, which would include bringing in the fair value from Schedule A and Schedule BA.

Mr. Barlow asked if these fair value amounts are for informational purposes or whether they are used for something in the investment schedules.

Mr. Bruins said he is not sure. He said the base real estate schedule in life RBC, LR007, will have no changes but is fed from four supporting worksheets in the forecasting file, which are identical but address different categories of real estate. He said the changes are detailed in the following pages of the presentation.

To Mr. Barlow’s question and based on his time as NAIC staff support for the Investment Risk-Based Capital (E) Working Group and exam work that he has done, Ed Toy (Risk & Regulatory Consulting—RRC) said he is confident that the fair values are not actually used for anything in the investment schedules for real estate. He said what he has seen in these fields ranges anywhere from being blank to being something that probably is related to the fair value of the property or being a fair value of the mortgage, so even though there are instructions for these fields, how companies are using and populating it ranges all over the place. He expressed a similar concern with the amount of encumbrances companies are reporting.

Mr. Barlow asked Dave Fleming (NAIC) to look into any review or analysis of these fields by the NAIC.

The Working Group agreed to expose the structural changes proposed for real estate by the ACLI, with a modification to make the fair value adjustment a stand-alone factor and not an embedded amount, for a public comment period ending March 8, noting that the proposal includes factors and instructions that are not final.

2. **Agreed to Forward the Guaranty Fund Memorandum to the Capital Adequacy (E) Task Force**

Mr. Barlow said this item has been discussed during previous meetings, and the consensus was that there was no action by the Working Group required in response to the changes to the *Life and Health Insurance Guaranty Association Model Act* (#520). He said a memorandum to that effect has been drafted and addressed to the Capital Adequacy (E) Task Force.

He asked if there were any concerns before forwarding the recommendation to the Task Force (Attachment Three-C2). The Working Group directed NAIC staff to forward the memorandum to the Task Force.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
Real Estate RBC: Structural Changes

January 2021
Agenda

- Brief overview of proposal
- Overview of adjustment for unrealized gain/loss
- Overview of encumbrance calculation
- Review of the Real Estate worksheets and specific changes
- Questions
Proposal

- Schedule A: Factor for Real Estate Equity investments
- Schedule BA: Proposed treatment consistent with Schedule A
- Adjustment for Unrealized Gain/Loss
- Update factor for RBC Adjustment for Real Estate Encumbrances
Unrealized Gain/Loss

- Statutory value for real estate is depreciated cost
- RBC looks at risk of loss of statutory capital
- If market value increases while depreciated cost decreases, there is typically a growing unrealized gain. That gain provides a margin before any statutory capital is lost.
- The proposal is to modify the base factor proportional to 2/3 of the unrealized gain, on a property by property basis
Unrealized Gain/Loss

The formula for the adjusted factor would be:

\[ \text{Adj Factor} = \text{RE Factor} \times (1 - \frac{2}{3} \times \frac{\text{MV} - \text{BV_g}}{\text{BV_g}}) \]

<table>
<thead>
<tr>
<th>BV</th>
<th>MV</th>
<th>Adj RBC</th>
</tr>
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<tr>
<td>100</td>
<td>50</td>
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<tr>
<td>100</td>
<td>150</td>
<td>6.7%</td>
</tr>
<tr>
<td>100</td>
<td>200</td>
<td>3.3%</td>
</tr>
</tbody>
</table>
Encumbrances

- Encumbrances are most commonly a mortgage on the property
- Real Estate is held on balance sheet at net value, i.e., depreciated cost less encumbrance
- Since the mortgage holder has the risk of the mortgage, risk is split between RE owner and the mortgage holder
- Encumbrance factor is RE factor minus commercial mortgage RBC factor
Encumbrances

- Currently addressed by having RBC as the sum of:
  - RE factor times net value, plus
  - Encumb. factor times encumbrance
- Proposal is to rearrange the terms of the algebra to be:
  - RE factor times gross RE value minus avg Comm. Mort factor times encumbrance
- With no change in factors, the RBC is the same. The formula change enables the adjustment for unrealized gain/loss.
## Encumbrances

### Formula Illustration

<table>
<thead>
<tr>
<th>TODAY'S FORMULA</th>
<th>PROPOSED FORMULA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Un-Encumbered</strong></td>
<td><strong>Encumbered</strong></td>
</tr>
<tr>
<td>Net BV</td>
<td>150</td>
</tr>
<tr>
<td>x RE RBC %</td>
<td>10%</td>
</tr>
<tr>
<td><strong>= RE RBC</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

Encumbrance

<table>
<thead>
<tr>
<th><strong>Un-Encumbered</strong></th>
<th><strong>Encumbered</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Encumbrance</td>
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</tr>
<tr>
<td>( \Delta (RE RBC % - CM RBC %) )</td>
<td>8.25%</td>
</tr>
<tr>
<td><strong>= Encumbrance RBC</strong></td>
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</tbody>
</table>

RE + Encumbrance RBC

<table>
<thead>
<tr>
<th><strong>Un-Encumbered</strong></th>
<th><strong>Encumbered</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>RE + Encumbrance RBC</td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Un-Encumbered</strong></th>
<th><strong>Encumbered</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Net BV + Encumbrance &amp; Gross BV</td>
<td>150 &amp; 100</td>
</tr>
<tr>
<td>x RE RBC %</td>
<td>10%</td>
</tr>
<tr>
<td><strong>= RE RBC</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

Encumbrance

<table>
<thead>
<tr>
<th><strong>Un-Encumbered</strong></th>
<th><strong>Encumbered</strong></th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>( \Delta CM RBC %)</td>
<td>1.75%</td>
</tr>
<tr>
<td><strong>= Encumbrance RBC</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

RE - Encumbrance RBC

<table>
<thead>
<tr>
<th><strong>Un-Encumbered</strong></th>
<th><strong>Encumbered</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>RE - Encumbrance RBC</td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>
Real Estate Worksheets

- LR007 is the Life RBC page for RE, and will have no changes
- All changes are in the worksheets, which are tabs:
  - Real1: Company Occupied Real Estate
  - Real2: Real Estate acquired by Foreclosure
  - Real3: Investment real estate
  - Real4: Schedule BA real estate
- These 4 sheets are identical, separated only by the types of properties that are reported on each.
- The proposed modifications are also identical to each
- For discussion today, we will look at real3 – investment real estate
Real Estate Worksheets

- Column 1 –
  - While generally the same, please look down to the line for Properties without encumbrances
  - Currently and in the past, all such properties were aggregated to a single line
  - The proposal will have the properties entered individually, each on a separate line. This is to accommodate the unrealized gain adjustment which is determined property by property.

- Column 2 is unchanged
- Column 3 is unchanged
Real Estate Worksheets

- Column 4 is a new column showing the fair value from Schedule A column 10 or Schedule BA column 12 as appropriate
- Column 5 is the base real estate RBC factor
- Column 6 is the encumbrance credit rather than the encumbrance factor
- Column 7 is a new column and is the adjusted RBC factor. This is where the adjustment is made for the unrealized capital gains.
Real Estate Worksheets

- Column 8 is the Gross RBC value, which is the adjusted factor times the gross value of columns 2 plus 3
- Column 9 is the encumbrance adjustment which is column 3 times column 6
- Column 10 is column 8 minus column 9.
  - Floor of BACV times NAIC2 bond factor
  - Cap of BACV times 45%
MEMORANDUM

TO: Tom Bostko (OH), Chair, Capital Adequacy (E) Task Force

FROM: Philip Barlow (DC), Chair, Life Risk-Based Capital (E) Working Group

DATE: January 21, 2021

RE: Recommendation Regarding Risk-Based Capital Charge for Guaranty Association Assessment Risk

The Life Risk-Based Capital (E) Working Group received a request from the Capital Adequacy (E) Task Force to review the referral letter regarding adopted amendments to the Life and Health Insurance Guaranty Association Model Act, Model #520. The referral outlined significant amendments to Model #520, including: 1) broadening the assessment base for long-term care insurance (LTCI) insolvencies to include both life and health insurers and splitting the assessment 50%/50% between the life and health insurers; 2) clarifying the guaranty associations’ coverage of LTCI; and 3) including health maintenance organizations (HMOs) as members of the guaranty association, similar to other health insurers. The referral letter requested that the Task Force consider if changes were warranted to the life RBC formula in light of the changes made to Model #520.

The reason for this item being referred to the Working Group was concern with the fact that the C-4a risk component is based on the amount of guaranty fund assessments. The risk charge is based on the maximum amount of assessments in any one year for a life company, and that is not affected by the changes to Model #520.

Based on the current instructions and reporting, the Working Group does not believe that modifications to the life RBC formula are required for the change to Model #520.

The recommendation above does not preclude the Working Group from potential changes to long-term care or the business risk component charge in the future.

If you have any questions regarding this memorandum, please contact me at philip.barlow@dc.gov or Dave Fleming (NAIC) at dfleming@naic.org.
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Dec. 17, 2020. The following Working Group members participated: Philip Barlow, Chair (DC); Steve Ostlund (AL); Thomas Reedy (CA); Deborah Batista (CO); Wanchin Chou (CT); Sean Collins (FL); Vincent Tsang (IL); John Robinson (MN); William Leung (MO); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner (TX); and Tomasz Serbinowski (UT).

1. **Received an Update on ESGs**

Mr. Barlow reminded the Working Group that work is being done on economic scenario generators (ESGs). While this will affect both reserves and capital, he said the work is being done primarily at the Life Actuarial (A) Task Force.

Pat Allison (NAIC) said there will be a meeting of the Task Force later today that will be focused on the new ESG. She said there was a discussion on Dec. 3, 2020, about the interest rate generator, noting that today’s discussion will be on the equity and corporate bond models and the potential exposure of a variety of materials for comment. She said these discussions also present goals for the ESG, along with the decisions that state insurance regulators will need to make. The work includes the development of a set of recommendations for each of those decisions for exposure.

Ms. Allison said the NAIC’s selected vendor, Conning, has calibrated its model to reflect those recommendations, so a full set of what is being referred to as the basic data set, which is what is intended to be prescribed, will be exposed. She said this is not what is intended for a field test, and it is certainly not final, as numerous comments are expected.

2. **Discussed the ACLI’s Real Estate Proposal**

Mr. Barlow reminded the Working Group that the American Council of Life Insurers (ACLI) developed a real estate proposal as part of the work of the Investment Risk-Based Capital (E) Working Group. He said this has now been moved to the Life Risk-Based Capital (E) Working Group, along with the work on the bond factors, and the intention is to address both at the same time to have them in place for year-end 2021, but it has been some time since this proposal was reviewed.

Steven Clayburn (ACLI) presented an overview of the proposal to assist the Working Group in determining the next steps to be taken. As Mr. Barlow indicated, he said this proposal was presented to the Investment Risk-Based Capital (E) Working Group in 2015, and it was exposed for comment on two occasions. He said there was some, although not universal, consensus at the time that the factors were too high, but what to do to lower those factors remained outstanding. With feedback from state insurance regulators and industry, he said the proposal was revised in 2017, but it was put on hold in 2018 to focus on the proposed revision to bond factors.

Mr. Clayburn provided a recap of the most recent discussions and the concerns expressed, as shown on Page 4 of the presentation. The proposal has four parts, as included on Page 5 of the presentation, and he discussed these in more detail, as provided in the remaining pages of the presentation. He said there are structural changes associated with the proposal, and he thanked the Life Risk-Based Capital (E) Working Group for making time for this presentation.

Dave Fleming (NAIC) said the structural change is actually to underlying worksheets that are included in the forecasting file, and the deadline for exposure of those is the end of January 2021.

Mr. Barlow said the analysis behind the proposal is a few years old, and he asked if the ACLI has any updates to that information. Mr. Clayburn said he believed there had been updates to the modeling in response to previously raised items, but he said he would verify that.

Mr. Barlow asked if there is some analysis or commentary that can be provided to address the current situation. Mr. Clayburn said he would take this back to the ACLI membership.

With respect to additional analysis, Mr. Chou asked about the analysis used in the derivation of the current factors.
Mr. Clayburn said he believes this information is included in the original proposal document, but he said he believes the current factor for Schedule A real estate is based on 60% of the common stock factor and Schedule BA was then 150% of that result. He said this was not based on true analysis, but because there was not much data at the time, it was a conservative approach.

Paul S. Graham (ACLI) said there was data from two companies used back in the 1980s that resulted in the use of a percentage of the stock equity factor for real estate. At the time, he said it was not that material because there was not a lot of industry invested in it, but in the current environment of lower interest rates where companies are trying to back their promises to policyholders with assets that have a little higher return, it is becoming more important.

Mr. Graham said the original study the ACLI did in 2015 showed factors below the 8% that was recommended, and the fact that there may be more current experience that is not as good because of COVID-19, coupled with the factor now being discussed at 10%, it is likely covered.

Mr. Barlow asked if the growth is in real estate or items reported on Schedule BA. Mr. Graham said he believes it is both, but he noted that the proposal is to look not only at the book value but also the market value so investments, other than those done at the beginning of 2020, would have that buffer.

Mr. Tsang asked if the ACLI could include information with respect to the materiality of these investments to its member’s portfolios and the impact of the proposed factors on its capital requirements. Mr. Clayburn said the ACLI would work with the members on impact.

Mr. Barlow asked if the exposure would be something captured in the NAIC’s database. Mr. Fleming said it is and he would work on providing that information.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
March 8, 2021

Philip Barlow
Chair
Life Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Dear Philip,

On behalf of the American Academy of Actuaries\(^1\) C-1 Work Group (C1WG), we appreciate the opportunity to provide comments on the exposed January 21, 2021, proposal to restate the capital requirements for real estate in the Life Risk-Based Capital (LRBC) formula. The C1WG is generally supportive of a different approach for calculating capital requirements for real estate. As 30 years have passed since the current real estate factors were set, a review of the capital requirements is a prudent exercise. The C1WG has reviewed the proposal and is unable to find agreement with the proposal without additional justification/explanation. In reviewing the proposal, we have the following conceptual concerns:

1. Market Value vs. Statutory Value Issues

   Establishing capital requirements based on market value inputs when real estate is carried at amortized cost in statutory financial statements is a departure from RBC precedents. Clearly, changing statutory accounting to a market value basis and determining capital requirements directly on those market values would be a more direct approach. With a restatement to market value, both total adjusted capital and the required capital calculation would be different (i.e., both the numerator and the denominator of the RBC ratio would change).

   It appears that the proposed structure is an attempt to fix the current LRBC approach that overstates capital requirements by applying a market risk measure to depreciated book value by inserting an adjustment involving unrealized capital gains. Taken together, this approach is intended to reflect the likely lower risk of loss to statutory surplus.

\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
While the work group agrees there should be work to refine the capital charge to recognize the likely lower risk to statutory surplus than the current approach has produced, the use of a market basis risk measure combined with the offset of a portion of unrealized gains to state the risk to capital of an asset valued under statutory rules on a book value basis is unsupported by either fact or theory. Statutory accounting holds real estate at cost less accumulated depreciation unless there is an impairment. At impairment, a restated holding value at market incurs a loss (if less than current book value). Assuming real estate generally increases in value over time, losses measured on a book value basis will be less than those determined on a market value basis.

The use of an arbitrary portion of unrealized gains to convert the market risk measure to the actual book value measure of this asset class is not a supportable approach in the determination of statutory capital requirements. Simply stated, the proposed 2/3 adjustment is not supported by a factual analysis. The capital requirements should be derived based on the likelihood of the occurrence of loss measured as the amounts of future book loss amounts over an appropriate horizon and stated degree of statistical confidence. Developing the adjustment directly from a statutory-based model would provide support for the proposed 2/3 adjustment. A more direct approach could involve a factor for a specific market to book value combination applied directly to depreciated book without further adjustments.

Because of these issues, we have concerns over the reliability of using market measures and unrealized gains to replicate the actual risk of loss on a statutory book basis. As noted above, we suspect the risk is lower than a pure market risk, but do not know how much lower it might be. If this recommended approach were used, is the 2/3 adjustment too high or too low, and could it vary depending on specific conditions? Without more information shared about how the adjustment converts the market measure to a book value, we are unable to come to disposition on the proposed approach. Further, we are concerned that using one scalar applied to the difference between market value and book value would achieve the desired result. If there is a linear relationship between the unrealized loss and the 95th percentile of book value impairments, a scalar might be appropriate, but the C1WG is not convinced of this linear relationship.

We also would question the minimum condition of the NAIC 2 bond factor because there is no clear rationale provided for the relationship between the bond factor used to capture credit risk and real estate capital requirements.

Lastly, we too would raise the question from the February 26, 2021, Life RBC Working Group meeting as to whether it is appropriate to use a market determined risk measure,
the base factor, in combination with unrealized gains where gains (and losses) are already implicit in the statutory base measure itself.

2. Implementation Issues with the Use of a Market Value Measure

If the capital requirements are amended to include a market value measure, specific instructions are needed to define how market value is to be calculated. The LRBC formula needs to be calculated using a consistent definition of the market value calculation, as was done in establishing capital requirements for commercial mortgages.

3. Recommended Statistical Safety Level

The proposal is based on a Statistical Safety Level at the 95th percentile over a 2.5-year time period; what is the basis for the recommended time horizon? The time horizon for bonds was set at 10 years, the typical credit cycle for bonds; what does the 2.5-year period represent? This recommendation moves away from current capital requirements determined relative to those for common stock (i.e., based on a 60% correlation); as such, a time horizon based on the volatility of market returns for an asset carried at amortized cost does not seem consistent with the principles of statutory RBC.

4. Assuming Same Risk Profile for All Types of Real Estate

a. The proposal is recommending nearly identical treatment for all types of real estate. The C1WG would need to see the data that supports the conclusion that the risk profiles for real estate reported on Schedule A are similar to the risk profiles for real estate reported on Schedule BA; our understanding is that the difference in risk drives different reporting. In particular, we would need to better understand how encumbrances can be determined and reported on a look-through basis on Schedule BA so that the implementation of the proposal will reflect the spirit of accurately identifying risk on a look-through basis.

b. While real estate is a relatively small asset class for the life insurance industry (approximately 1% of invested assets), using one factor for all types of real estate may not be an appropriate representation of the various risks within the real estate sector. We note that commercial mortgages on hotel properties receive different LRBC treatment, establishing a precedent for different experience for hotel properties. Further, as noted during the February 26, 2021, Life RBC Working Group meeting, using the same factor for distressed properties raises additional concerns.
c. Properties in development are riskier than properties that are producing income. While there may be materiality and other practical considerations, should different capital requirements be established?

We recognize the importance of this asset class for life insurers and support the review of the capital requirements. However, we continue to have concerns with several aspects of the proposal. We acknowledge that the current LRBC capital requirements may be overstated for certain real estate investments (e.g., where the market value exceeds statutory value by a large amount). Fundamentally, the risk to statutory surplus is less for real estate properties whose statutory value is less than the market value. Consequently, a reduction to the capital requirements has merit, but the proposal’s approach to start with market value returns and then adjust statutory values is complex and may not achieve the desired level of required capital that a more direct calculation could produce.

Again, thank you for the opportunity to provide the C1WG comments and should you have any questions or wish to discuss anything in these comments, please contact Khloe Greenwood, the Academy’s life policy analyst (greenwood@actuary.org).

Sincerely,

Nancy Bennett, MAAA, FSA, CERA—Co-Chairperson, C1WG
Jerry Holman, MAAA, FSA, CFA—Co-Chairperson, C1WG

Copy: Dave Fleming, NAIC
TO: NAIC Life Risk-Based Capital Working Group
FROM: American Council of Life Insurers
DATE: March 9, 2021
RE: Review of Proposals from the PFML Federal Strategies Working Group

On Life RBC Working Group’s conference call of February 26, 2021, several questions were raised during ACLI’s presentation and discussion of the proposed changes to the RBC for Real Estate. The questions follow, and responses are provided on the following pages. We can further discuss these on an upcoming call of the Working Group.

1) Please provide additional detail and documentation of the modeling.

2) Please provide documentation of volumes of Real Estate.

3) Given that you apply the RBC charge to the smaller depreciated cost, and not to the full fair value, aren’t you somewhat double-counting by then adjusting the RBC rate based on the unrealized gain?

4) What is the confidence that the adjustment to the risk factors based on the relation of market and statutory book value does not result in an appropriately low RBC factor?

5) What happens when the market value declines to be less than the book value?
1) Please provide additional detail and documentation of the modeling.

This recommendation is based on analyses of actual historical performance of the National Council of Real Estate Investment Fiduciaries (NCREIF) Property Index, appended by data from a couple of other similar studies to extend our historical data back to 1961. The NCREIF Property Index (NPI) is the premier industry benchmark for measurement of institutional commercial real estate investment performance in the US. The NPI data begins in 4Q 1977 and is comprised of quarterly market value-based investment performance of assets acquired and held for investment purposes in a fiduciary environment. There is no minimum property size, and the asset can be held as wholly owned or through a joint venture. It includes a wide array of the primary institutional investment property types, including Office, Retail, Industrial, Apartment and Hotels. As of 4Q 2020, this index included more than 9,000 properties with over $700 billion in real estate market value. It is a robust and directly applicable index for measurement of the market value performance of life insurance company investment real estate, and it is the same data that is currently being used for updating of market values of Commercial Mortgage LTVs in support of the reporting of Commercial Mortgage Loan RBC.

We analyzed the historical sector performance and present the results in Section A of the proposal. We present results across 1, 2, 3 and 4 year analysis periods. In each of these four assumed analysis periods, we examine the historical data and calculate the largest cumulative losses that were observed at any time during the analysis period. The process was to take the index value as of a quarter, e.g., Q1-1961, and track the performance in each subsequent quarter of the respective analysis period. We started with index values at the beginning of the period and found the lowest index value at any quarter during the analysis period and calculated the change from the beginning. For example, for the 2-year analyses, we examined every potential 2-year period within the full data history, which resulted in 232 data points in the full data history. Our analysis found that for a 2-year analysis period, the 95% worst cumulative loss was 9.2% and the 96% worst cumulative loss was 9.7%. We thus recommend adoption of a 9.5% factor.

Lastly, we recommend a 1.5% cushion be added to the 9.5% factor that was estimated using the actual real estate performance history. This cushion is meant to address two primary areas of concern that surfaced in our individual outreach discussions: 1) that individual life insurance company portfolios may not be as diversified as the index used in estimation of the factor; and 2) that future real estate performance may not be similar to the past, especially in light of COVID-19. We believe the 1.5% is a reasonable cushion, and is supported by the following:

- The 1.5% cushion represents an additional 15% conservatism built in on top of the data-supported 9.5% factor. In effect, this means that market downturns can be 15% more severe than in the past, and the factor will still be sufficient to cover losses over two years at a 95% confidence level.
- At 11%, the applied factor would cover historical actual 2-year cumulative losses at an almost 97% confidence level.
- Thus far, the impact of COVID-19 on commercial real estate investments has been significant but have been concentrated in a relatively small segment of the market. The most impacted segments have been hotels and select lower quality regional malls. Overall, the NCREIF Property Index reports around a 1% return on real estate investments in 2020, which is meaningfully below the returns over the last few years, but still positive. Most industry experts do not expect COVID-19 to result in as rapid or severe deterioration as happened in the GFC.
As we cite in our proposal, we examined the distribution of properties by type and geographic region within life insurance company portfolios and found it to be similar in mix to that of the NCREIF Property Index. This suggests that the distribution of life insurance company investments in real estate are similar in composition to the index. However, given the risk that individual life insurance company portfolios’ composition could deviate meaningfully from the diversity of the overall life insurance company space, we believe that the 1.5% cushion is sufficient to cover this risk. Also, we note in our proposal that there are regulations separate from RBC factors that address concentration risks and assure diversification of life company real estate portfolios.

2) Please provide documentation of volumes of Real Estate.

- Real estate investments are a very small component of most life insurance portfolios. The following information is taken from 2019 Annual Statement data.
- Real estate investments represent only 1.29% of Life Company GA assets.
  - Total General Account is $4,812,938 million
  - Total Real Estate $61,972 million
    - Schedule A $23,358 million
    - Schedule BA $38,613 million
- Life company real estate investments are spread across both Schedule A and Schedule BA, with Schedule A accounting for 0.49% and Schedule BA accounting for 0.80%.
- Of 761 life insurance companies, 587 (77%) have less than 0.25% of assets in Schedule A real estate, and 677 (89%) have less than 0.25% of assets in Schedule A real estate.
- Company occupied real estate accounts for a meaningful component of Schedule A real estate exposures in many companies.
  - Of the 174 companies with 0.25% or greater of their assets in Schedule A real estate, 64 (36.8%) of these companies are solely invested in company occupied properties.
  - The remaining 110 companies account for 96.7% of Sch. A real estate, and it constitutes 1.14% of their General Account assets.
    - Approx. 20% of this real estate is company occupied.
  - 59 of these 110 companies have less than $1B in assets. 3.3% of their GA assets are in RE, split 40% company occupied and 60% investment.
- For Schedule BA, ACLI conducted a survey in 2018 in response to similar questions from the Investments RBC Working Group. Appendix A is the memo that summarizes the results of that survey.

3) Given that you apply the RBC charge to the smaller depreciated cost, and not to the full fair value, aren’t you somewhat double-counting by then adjusting the RBC rate based on the unrealized gain?

- We do not believe there is “double-counting”, as that implies making two adjustments based on the same reason.
- When determining RBC generally, there are two facets to consider: 1) how much is at risk; and 2) what is the level of risk. Statutory Book Value is the amount that is included as the value of the company’s assets, and therefore determines the amount of surplus. A factor is applied to this book value, because that is the amount of surplus that is at risk. In statutory accounting, that value is a decreasing value as it is defined to be the depreciated cost.
• The factor that is used should reflect the likelihood of a loss. In the case of real estate, the relation of market and book values is a proxy to determine the amount of risk, where the greater the excess of market value over book value, the lower the risk to statutory surplus.

• Thus, that statutory values use a depreciated value, and that the factor adjustment uses the difference between market and book, are addressing two separate issues even though they appear to be making adjustments that are directionally the same.

4) What is the confidence that the adjustment to the risk factors based on the relation of market and statutory book value does not result in an appropriately low RBC factor?

We start with the premise of RBC - If a company holds assets equal to the existing book assets plus an amount of surplus equal to the RBC, then historically there have not been more than 5% of instances where the value declines by more than the RBC amount, and therefore assets do not fall below the book value. Thus, with an RBC factor of 11%, if market value provides unrecognized gain of more than 11% compared to book value, then 95% of the time the book value will not be reduced. In theory, any gain in excess of that creates a situation of zero risk relative to the 95% standard.

<table>
<thead>
<tr>
<th>Assumptions:</th>
<th>Credibility 2/3</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC factor</td>
<td>11.0%</td>
</tr>
<tr>
<td>RBC max factor</td>
<td>45%</td>
</tr>
<tr>
<td>RBC min factor</td>
<td>1.30%</td>
</tr>
<tr>
<td>95% max loss MV</td>
<td>9.50%</td>
</tr>
</tbody>
</table>

Table - Illustrate 95% certainty level of max BV loss

<table>
<thead>
<tr>
<th>Book Value (BV)</th>
<th>Market Value (MV)</th>
<th>95% Max Loss MV</th>
<th>Implied BV loss</th>
<th>95% loss as % of BV</th>
<th>RBC%</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>100</td>
<td>9.5</td>
<td>9.5</td>
<td>9.5%</td>
<td>11.00%</td>
</tr>
<tr>
<td>100</td>
<td>102.5</td>
<td>9.7</td>
<td>7.2</td>
<td>7.2%</td>
<td>10.82%</td>
</tr>
<tr>
<td>100</td>
<td>110</td>
<td>10.5</td>
<td>0.5</td>
<td>0.5%</td>
<td>10.05%</td>
</tr>
<tr>
<td>100</td>
<td>120</td>
<td>11.4</td>
<td>-</td>
<td>0.0%</td>
<td>9.53%</td>
</tr>
</tbody>
</table>

As you can see from the table above, the loss to book value in the event of a 95% level of certainty loss of market value is in all cases less than the adjusted RBC percentage, which is applied to book value. So we are more than 95% certain that the adjusted RBC factor is sufficient.

5) What happens when the market value declines to be less than the book value?

• Market value dropping below book is a trigger for review for impairment. However, all circumstances around property performance should be considered, for example loss of a major tenant in a specialized asset.
• There is robust statutory guidance (SSAP 90) around recognizing impairment of wholly-owned real estate. Joint ventures are accounted for under the equity method, and as such are financial assets.

• A write-down is taken if an impairment is present and is not temporary.

• Impairment review is based on modeling of cash flows and not on market values. There is a recoverability test that is based on comparing the expected undiscounted cash flow to the carrying value of the real estate. If cash flows are greater than carrying value, then there may not be an impairment. If the sum of the undiscounted cash flows are less than the carrying value, then the real estate would most likely be impaired. The actual impairment is measured as the difference between the carrying value and fair value of the real estate.

• Rules exist to distinguish temporary vs other than temporary. This a mechanical process so once carrying value is greater than the undiscounted cashflows, life companies are required to recognize a permanent (other than temporary) impairment.

• Thus, capital markets may indicate a lower current market value even when there is not a need to recognize a permanent Impairment.

• In our proposal, the MV/BV adjustment increases the RBC charge in this case, reflecting the possibility of a write down.
APPENDIX A – 2018 Memorandum on Schedule BA Real Estate

FROM:  Steve Clayburn
RE:  Real estate RBC proposal to the NAIC
      Schedule BA Characteristics – summary of survey results
DATE:  August 8, 2018

BACKGROUND
Since the inception of RBC, Schedule BA real estate has used a factor that is 150% of Schedule A’s factor. This premium was intended to account for the potential of additional risk associated with Schedule BA assets. The ACLI\(^1\) conducted a survey of its member companies on the characteristics of these assets, to provide transparency and support for its recommendation of equivalent factors for both Schedule A and Schedule BA assets.

SCHEDULE BA SURVEY RESULTS
Survey respondents represented approximately 70% of all real estate (Schedule A) reported by life insurance companies and nearly 50% of total general account assets. Of these real estate portfolios, approximately 40% is reported on Schedule A and 60% on Schedule BA.

The following is a summary of the real estate characteristics as reported on Schedule BA based on reported book value as of December 2017:

Ownership
- 80% Affiliated and 20% Unaffiliated
- 50% controlling interest that’s either wholly-owned or held in a joint venture with control, and 50% non-controlling interest held in a joint venture

Jeffrey Fisher, Ph.D., a consultant for NCREIF, found that real estate held in joint ventures performed consistently with, and perhaps slightly better than, wholly-owned real estate. For reference, based on assets in the NCREIF index, approximately 60% are wholly-owned and 40% are joint ventures by market value.

Risk Profile
- 71% Core – at least 80% leased and less than 10% under construction
- 16% Value-Add – less than 80% leased with less than 25% under construction

\(^1\) The American Council of Life Insurers (ACLI) advocates on behalf of approximately 290 member companies dedicated to providing products and services that contribute to consumers’ financial and retirement security. ACLI members represent 95 percent of industry assets, 93 percent of life insurance premiums, and 98 percent of annuity considerations in the United States. 75 million families depend on our members’ life insurance, annuities, retirement plans, long-term care insurance, disability income insurance and reinsurance products. Taking into account additional products including dental, vision and other supplemental benefits, ACLI members provide financial protection to 90 million American families.
- 13% Opportunistic – greater than 25% under construction

Diversification
- Property Type
  - 22% Office
  - 20% Multi-family
  - 11% Retail
  - 5% Industrial
  - 3% Lodging
  - 2% Mixed-Use
  - 37% Diversified – diversified real estate fund investments allocated to various property types, and also land, timber, parking garages and golf courses

- Geography
  - 26% Western U.S. (AS, AK, AZ, CA, CO, GU, HI, ID, MT, NMI, NV, NM, OR, TX, UT, WA, WY)
  - 23% Northeast U.S. (CT, DC, DE, ME, MA, MD, NH, NJ, NY, PA, RI, VT)
  - 11% Southeast U.S. (AL, AR, FL, GA, KY, LA, MS, NC, PR, SC, TN, VA, VI, WV)
  - 5% Midwest U.S. (IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, OK, WI)
  - 12% International (mostly South American agricultural land/timber)
  - 23% Diversified with less than 50% of an asset(s) in a specific zone

CONCLUSION

ACLI believes that these results provide more detail and allow one to assess Schedule BA asset characteristics and therefore risk.

Life insurance companies use local partners to source real estate investments and execute asset business plans, which leads to placement on Schedule BA. Jeffery Fisher’s study found use of joint venture partners can be beneficial to performance.

Over 70% of assets on Schedule BA are well-leased, long-term hold investments. Only 13% of assets are undergoing meaningful construction activity.

Similar to the NCREIF National Property Index, Schedule BA assets are diversified by both property type and geography.

The ACLI’s proposal to the NAIC adjusts real estate RBC factors for leverage as appropriate for both Schedule A and Schedule BA assets.

In conclusion, our survey demonstrates Schedule BA real estate is similar in ownership, risk and diversification to the properties underlying the NCREIF index which we used in developing our proposed real estate factors for Schedule A. Therefore, these results support our recommendation to equate Schedule A real estate factors to Schedule BA real estate factors.
The Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met March 15, 2021. The following Working Group members participated: Tom Botsko, Chair, and Dale Bruggeman (OH); Wanchin Chou (CT); Robert Ridenour (FL); Judy Mottar (IL); Anna Krylova (NM); Sak-man Luk (NY); Miriam Fisk (TX); and Randy Milquet (WI).

1) **Adopted the Minutes of the Catastrophe Risk (E) Subgroup and the Property and Casualty Risk-Based Capital (E) Working Group**

   a) **Catastrophe Risk (E) Subgroup**

   Mr. Chou said the Catastrophe Risk (E) Subgroup met March 8 and took the following action: 1) adopted its Jan. 27 minutes; 2) adopted proposal 2020-08-CR (Clarification to PR027 Interrogatories); 3) adopted proposal 2020-11-CR (Remove Operational Risk Factor from Contingent Credit Risk); 4) discussed the development progress of wildfire modeling and a risk-based capital (RBC) charge; 5) discussed its 2021 working agenda; 6) discussed the internal catastrophe model evaluation process; and 7) established an ad hoc group to conduct a more in-depth review on different wildfire models.

   Steve Brodie (American Property Casualty Insurance Association—APCIA) recommended the Subgroup take appropriate time to decide: 1) whether wildfire peril needs to be added to the Rcat component; and 2) how to implement the wildfire in the Rcat component if decision is made.

   b) **Joint Property and Casualty Risk-Based Capital (E) Working Group and Catastrophe Risk (E) Subgroup**

   Mr. Chou said the Property and Casualty Risk-Based (E) Working Group met in joint session with the Catastrophe Risk (E) Subgroup to conduct an e-vote that concluded Jan. 27 to adopt the updated 2020 U.S. and non-U.S. catastrophe risk event lists.

   Mr. Chou made a motion, seconded by Ms. Krylova, to adopt the Catastrophe Risk (E) Subgroup’s March 8 minutes (Attachment Four-A) and the joint Property and Casualty Risk-Based Capital (E) Working Group and Catastrophe Risk (E) Subgroup’s Jan. 27 minutes (Attachment Four-B). The motion passed unanimously.

2. **Adopted Proposal 2020-08-CR (Clarification to PR027 Interrogatories)**

   Mr. Chou said some insurers with minimal or no gross earthquake and/or hurricane exposure did not file PR027A or PR027B, and the Interrogatories on PR027 will create some validation issues in the catastrophe risk component. He said the purpose of this proposal is to add instructions to PR027 Interrogatories that clarify how insurers with minimal or no gross exposure to the catastrophe risk should complete the interrogatories. Mr. Chou also stated that the Subgroup received no comments during the exposure period.

   Mr. Chou made a motion, seconded by Mr. Luk, to adopt proposal 2020-08-CR (see *NAIC Proceedings – Spring 2021, Capital Adequacy (E) Task Force, Attachment Eight*). The motion passed unanimously.

3. **Adopted Proposal 2020-11-CR (Remove Operational Risk Factor from Rcat)**

   Mr. Chou said the operational risk is now separately addressed in the RBC formula as a stand-alone capital add-on. The purpose of this proposal is to remove the embedded 3% operational risk charge in the Rcat component to avoid double-counting of the charge. He also stated that the Subgroup received comment letters from the APCIA and Reinsurance Association of America (RAA) during the exposure period. They both support this proposal to eliminate the duplicative application of operational risk charges for modeled reinsurance recoverable in the Rcat component.

   Mr. Chou made a motion, seconded by Ms. Krylova, to adopt proposal 2020-11-CR (see *NAIC Proceedings – Spring 2021, Capital Adequacy (E) Task Force, Attachment Nine*). The motion passed unanimously.
4. **Received an Update from its Subgroup on the Development Process of Wildfire Modeling and an RBC Charge**

Mr. Chou said understanding the wildfire model and engaging the state insurance regulators and industry to get involved in the development of the RBC charge are the two key elements of implementing the RBC charge properly. He stated that the Subgroup met three times since the 2020 Fall National Meeting in regulator-to-regulator session to discuss wildfire models. He said the Subgroup planned to continue with more in-depth technical reviews of different model assumptions, limitations and impact studies in the upcoming months. Also, Mr. Chou urged the interested parties to provide thoughts regarding the wildfire peril during Subgroup’s next meeting on: 1) other key items to be considered during the RBC charge development phases; 2) using the worst year in 100 in the calculation of the RBC charge; and 3) expected actual implementation reporting year.

5. **Exposed Proposal 2021-03-P (Credit Risk Instruction Modification)**

Mr. Botsko said the purpose of this proposal is to provide examples to clarify how the reporting companies should select the designation in the Annual Statement Schedule F, Part 3, Reinsurer Designation Equivalent Rating column if the reporting entities subscribe to one or multiple rating agencies. He also stated that since the accurate reporting on reinsurer designation equivalent rating in the Schedule F, Part 3 is crucial to calculate the R3 charge appropriately, NAIC staff will conduct a more in-depth review on Schedule F, Part 3 in the near future. The Working Group agreed to expose proposal 2021-03-P for a 30-day public comment period ending April 14.

6. **Heard an Update from its Runoff Ad Hoc Group**

Mr. Botsko said an ad hoc group was formed to determine the best course of treatment of run-off companies during the 2020 Fall National Meeting. Mr. Botsko stated that the ad hoc group identified those companies that: 1) stopped renewing policies for at least 12 months; 2) are closed to new business; 3) are large on reserves to premium written ratio; and 4) have zero premium written on the reserves to premium written ratio. He also stated that the ad hoc group is reviewing: 1) the possibility of adding an identifier in the annual statement; and 2) the current RBC calculation, including R5 and the operational risk components. Since different lines of business may have their own definition of runoff, Mr. Botsko said the ad hoc group will share its progress and findings with not only the Working Group and the Restructuring Mechanisms (E) Subgroup, but also the Life Risk-Based Capital (E) Working Group and Health Risk-Based Capital (E) Working Group for their consideration.

7. **Adopted its 2021 Working Agenda**

Mr. Botsko summarized the changes to the Working Group’s 2021 working agenda: 1) changed “Evaluate other catastrophe risks for possible inclusion in the charge” item expected completion date to year-end 2022 or later; 2) removed “Evaluate the possibility of using the NAIC as a centralized location for reinsurer designations” and “Evaluate the RBC impact on two different retroactive reinsurance exception approaches”; 3) modified “Evaluate the possibility of allowing additional third-party models to calculate the cat model losses” to “Evaluate the possibility of allowing additional third-party models or adjustments to the vendor models to calculate the cat model losses,” and the expected completion date was changed to year-end 2021 or later; and 4) added “Implement Wildfire Peril in the Rcat component (For Informational Purpose Only)” in the new items section.

Mr. Chou made a motion, seconded by Mr. Luk, to adopt the Working Group’s 2021 working agenda (see NAIC Proceedings – Spring 2021, Capital Adequacy (E) Task Force, Attachment Ten). The motion passed unanimously.

8. **Heard Updates on Property/Casualty RBC Underwriting Risk Factors from the Academy**

David Traugott (American Academy of Actuaries—Academy) said the Academy report Update to Property and Casualty Risk-Based Capital Underwriting Factors Experience Through December 31, 2017 (Attachment Four-C) was based on data from annual statements reporting between 1989 and 2017 and RBC filings between 1997 and 2017. He stated that the approach in this report is broadly the same as the approach in the 2016 report, with some refinements. Mr. Traugott also said the Academy planned to devote more time to discuss this report in the upcoming Working Group meeting to allow state insurance regulators and interested parties to have chance to review it. In addition, he stated that the investment income adjustment factors and the loss/premium concentration factor reports will be provided to the Working Group later. Mr. Botsko said he planned to schedule another meeting to discuss this report and other Working Group outstanding items in April.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group adjourned.
The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met March 8, 2021. The following Subgroup members participated: Wanchin Chou, Chair (CT); Robert Ridenour, Vice Chair (FL); Laura Clements (CA); Gordon Hay (NE); Anna Krylova (NM); Halina Smosna and Sak-man Luk (NY); Tom Botsko (OH); Andrew Schallhorn (OK), Will Davis (SC); and Miriam Fisk (TX).

1. **Adopted its Jan. 27 Minutes**

Mr. Chou said the Subgroup conducted an e-vote that concluded Jan. 27 to adopt the updated proposal 2020-12-CR (2020 U.S. and Non-U.S. Catastrophe Risk Event Lists).

Mr. Botsko made a motion, seconded by Ms. Clements, to adopt the Subgroup’s Jan. 27 minutes (Attachment Four-B). The motion passed unanimously.

2. **Adopted Proposal 2020-08-CR (Clarification to PR027 Interrogatories)**

Mr. Luk said some insurers with minimal or no gross earthquake and/or hurricane exposure did not file PR027A or PR027B, and the Interrogatories on PR027 will create some validation issues in the catastrophe risk component. He said the purpose of this proposal is to add instructions to PR027 Interrogatories that clarify how insurers with minimal or no gross exposure to the catastrophe risk should complete the interrogatories.

Mr. Chou stated that the Subgroup received no comments during the exposure period.

Mr. Luk made a motion, seconded by Mr. Botsko, to adopt proposal 2020-08-CR (see NAIC Proceedings – Spring 2021, Capital Adequacy (E) Task Force, Attachment Eight). The motion passed unanimously.

3. **Adopted Proposal 2020-11-CR (Remove Operational Risk Factor from Rcat)**

Mr. Botsko said the operational risk is now separately addressed in the risk-based capital (RBC) formula as a stand-alone capital add-on. The purpose of this proposal is to remove the embedded 3% operational risk charge in the Rcat component to avoid double-counting of the charge. He also stated that the Subgroup received two comment letters during the exposure period.

Stephen W. Broadie (American Property Casualty Insurance Association—APCIA) and Scott Williamson (Reinsurance Association of America—RAA) support this proposal to eliminate the duplicative application of operational risk charges for modeled reinsurance recoverable in Rcat component.

Mr. Botsko made a motion, seconded by Mr. Davis, to adopt proposal 2020-11-CR (see NAIC Proceedings – Spring 2021, Capital Adequacy (E) Task Force, Attachment Nine). The motion passed unanimously.

4. **Discussed Wildfire Modeling and RBC Charge Development Progress**

Mr. Chou said understanding the wildfire model and engaging the state insurance regulators and industry to get involved in the development of the RBC charge are the two key elements of implementing the RBC charge properly. He stated that the Subgroup met three times since the 2020 Fall National Meeting in regulator-to-regulator session to discuss wildfire models. He said the Subgroup planned to continue with more in-depth technical reviews of different model assumptions, limitations and impact studies in the upcoming months.

Also, Mr. Chou urged the Subgroup to provide thoughts regarding the wildfire peril during its next meeting on: 1) other key items to be considered during the RBC charge development phases; 2) using the worst year in 100 in the calculation of the RBC charge; and 3) expected actual implementation reporting year. He stated that a meeting will be scheduled in the near future to continue discussing this issue.
Mr. Broadie said developing an appropriate charge for the wildfire peril is crucial; he recommended that the Subgroup should consider taking time on the development progress. Mr. Chou agreed.

5. **Adopted its 2021 Working Agenda**

Mr. Chou summarized the changes to the Subgroup’s 2021 working agenda: 1) changed “Evaluate other catastrophe risks for possible inclusion in the charge” item expected completion date to year-end 2022 or later; 2) modified “Evaluate the possibility of allowing additional third-party models to calculate the cat model losses” to “Evaluate the possibility of allowing additional third-party models or adjustments to the vendor models to calculate the cat model losses,” and the expected completion date was changed to year-end 2021 or later; and 3) added “Implement Wildfire Peril in the Rcat component (For Informational Purpose Only)” in the new items section.

Ralph Blanchard (Travelers) asked the Subgroup to consider changing the expected completion date of implementing wildfire peril in the Rcat component for informational purpose only to after the 2022 Spring National Meeting.

Mr. Botsko made a motion, seconded by Mr. Schallhorn, to adopt the Subgroup’s 2021 working agenda (see NAIC Proceedings – Spring 2021, Capital Adequacy (E) Task Force, Attachment Ten), with the change of the expected completion date for “Implement Wildfire Peril in the Rcat component (For Informational Purpose Only).” The motion passed unanimously.

6. **Discussed the Internal Catastrophe Model Evaluation Process**

Mr. Chou said there are three different kinds of CAT models that deviate from the vendor models: 1) internal CAT models; 2) vendor CAT models with adjustments or different weights; and 3) derivative models based on the vendor models. He stated that detailed instructions in evaluating the internal CAT models have been included in the RBC instructions. However, he said he thinks more in-depth instructions on the derivative model and the vendor models with adjustments may be necessary.

Mr. Botsko recommended that the Subgroup should take wildfire peril into consideration as it continues discussing this issue.

Mr. Blanchard said a different level of evaluation and validation process should be applied to vendor CAT models with adjustments or different weights. He said he believes that a more simplified instructions is worthy of consideration for this type of model.

Mr. Chou asked all the interested parties to share thoughts during the Subgroup’s upcoming meeting.

7. **Created an Ad Hoc Group to Review Wildfire Models**

Mr. Chou said he believes that creating a technical review ad hoc group to conduct a more in-depth review on different wildfire models would speed up the entire wildfire charge development progress. He said encourages interested parties to join the ad hoc group so this project will be completed in time.

Having no further business, the Catastrophe Risk (E) Subgroup adjourned.
The Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force conducted an e-vote with the Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force that concluded Jan. 27, 2021. The following Working Group members participated: Tom Botsko, Chair (OH); Richard Ford (AL); Laura Clements (CA); Mitchell Bronson (CO); Wanchin Chou (CT); Robert Ridenour (FL); Judy Mottar (IL); Anna Krylova (NM); Sak-man Luk (NY); Will Davis (SC); Miriam Fisk (TX); and Randy Milquet (WI). The following Subgroup members participated: Wanchin Chou, Chair (CT); Robert Ridenour, Vice Chair (FL); Mitchell Bronson (CO); Judy Mottar (IL); Gordon Hay (NE); Anna Krylova (NM); Sak-man Luk (NY); Tom Botsko (OH); Andrew Schallhorn (OK); Will Davis (SC); and Miriam Fisk (TX).

1. **Adopted the Updated 2020 U.S. and Non-U.S. Catastrophe Risk Event Lists**

The Working Group and the Subgroup conducted an e-vote to consider adoption of the updated 2020 U.S. and non-U.S. catastrophe risk event lists.

Ms. Krylova made a motion, seconded by Mr. Bronson, to adopt the lists *(see NAIC Proceedings – Spring 2021, Capital Adequacy (E) Task Force, Attachment One-A)*. The motion passed unanimously.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group and the Catastrophe Risk (E) Subgroup adjourned.

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Report to the
National Association of Insurance Commissioners
Property and Casualty Risk-Based Capital (E) Working Group

Update to
Property and Casualty Risk-Based Capital
Underwriting Factors
Experience Through December 31, 2017

Presented by the American Academy of Actuaries¹
Property and Casualty Risk-Based Capital Committee
March 2021

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policy makers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
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NAIC support provided by SakMan Luk, Eva Yeung and Jane Barr
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1. INTRODUCTION

The American Academy of Actuaries Property and Casualty Risk-Based Capital Committee ("Committee" or "We") prepared this Report ("Report") at the request of the National Association of Insurance Commissioners’ ("NAIC") Property and Casualty (P&C) Risk-Based Capital (RBC) Working Group ("NAIC Working Group" or "Working Group").

In this Report, we present indicated Line of Business ("LOB") Underwriting ("UW") Risk Factors for the P&C RBC Formula ("RBC Formula" or "Formula"), specifically, RBC Line 4 on pages PR017 and PR018 for the Formula. We refer to these LOB UW Risk Factors as the “Reserve Risk Factor” ("RRF") and the “Premium Risk Factor” ("PRF"), respectively, or “Risk Factors,” generically.

This is the first in a series of three reports. The results of this review will be input to subsequent Reports 2 and 3 that will address the following:

- Report 2—Investment Income Adjustment ("IIA")—RBC Line 8 on page PR017 (R4 UW Risk - Reserves) and Line 7 on page PR018 (R5 – UW Risk – Net Written Premium), by LOB.
- Report 3—Loss Concentration Factor ("LCF") and Premium Concentration Factor ("PCF")—RBC Line 14 on PR017 and PR018 respectively.

We describe the full scope of this three-part project in a letter to the NAIC Working Group dated May 9, 2019, that is attached as Appendix 15 in this Report. We plan to issue Reports 2 and 3 later this year.

We provide these indicated Risk Factors for the information of the NAIC Working Group. Report 2—Investment Income Adjustment, to be provided later this year, may also be useful in informing NAIC Working Group action related to the indicated UW Risk Factors in this Report.2

This work by the Committee builds on prior American Academy of Actuaries reports on UW Risk Factors, most recently in 2010 and 2016, which we refer to as the 2010 Report and the 2016 Report, respectively. We also use Casualty Actuarial Society (CAS) RBC research prepared by the CAS Dependency and Calibration Working Party (DCWP). We list this American Academy of Actuaries and CAS material in the Reference Section, Appendix 14.

The analysis presented in this Report is based on data evaluated through December 31, 2017. The analysis in the 2016 report was based on data evaluated through December 31, 2014.

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2 The IIA Report will address the fact that the current IIA’s are based on a 5% interest rate, even though current interest rates are much lower. It is likely that the effect of reflecting lower interest rates will increase the overall risk charges.
2. FINDINGS

Indicated Risk Factors
Using the data and methodology described in this Report, we calculate the indicated Risk Factors. We compare the indicated factors to (a) indicated Risk Factors from the 2016 Report and (b) the Risk Factors in the 2020 RBC Formula in tables below:

- In Tables 1a and 1b we compare the Risk Factors indicated by the current analysis to the Risk Factors indicated in the 2016 Report. This comparison shows us the effects of changes in methodology and additional data for this Report compared to the 2016 Report.

- In Tables 1c-1e we show the effect on RBC values of moving from the Risk Factors in the 2020 RBC Formula to the Risk Factors indicated by this analysis. Appendix 13 provides further details on the effect of that change, and also the effects of “capping” the changes, using the capping rules the NAIC Working Group considered in evaluating the 2016 Report.  

Table 1a shows the following information:

- Columns 2 and 5—The factors in the “2020 RBC Formula” column are those used in the 2020 RBC Formula, except that, for catastrophe exposed LOBs, we increase the 2020 Risk Factors to their values before the NAIC catastrophe risk adjustments. 


- Columns 4 and 7—The Risk Factors in the “Indicated (2017 Data)” columns are the indicated Risk Factors from this study, using data evaluated through December 31, 2017.

The all-lines average indicated Risk Factors in the analysis are relatively close to the all-lines average indicated Risk Factors from the 2016 analysis. Nonetheless, there are some notable changes in Risk Factors by LOB.

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3 While we provide this detailed information, as noted in the Introduction, the results of our IAA Report may provide more context for any changes in Line 4 Risk Factors.

4 Beginning in 2016, the RBC Formula includes a new risk component, RCat, covering earthquake and hurricane components of the total premium risk. The indicated PRFs in this Report and in the 2016 Report have been calibrated with data that included earthquake and hurricane losses. Therefore, to avoid double counting of catastrophe risk, the NAIC developed a procedure to reduce the otherwise applicable Risk Factors for the affected LOBs. The factors that reduce the indicated PRFs to an ex-cat basis by LOB are as follows: Homeowners (0.971), CMP (0.980), Special Liability (0.983), Special Property (0.982), and Reinsurance: Nonproportional Assumed Financial, collectively called (“Reinsurance Property”) (0.944).

5 The indicated Risk Factors do not reflect the transition rules, often referred to as ‘capping’, that the NAIC requested.

6 The NAIC has adopted a portion of the indicated Risk Factors from the 2016 Report in several steps from 2016 to 2019. The remaining differences between the 2019 Risk Factors and the indicated Risk Factors contained in the 2016 Report are due to NAIC capping for those LOBs that has not yet been removed.

7 These indicated Risk Factors do not reflect any transition rules, often referred to as “capping,” that the NAIC might request.
If the NAIC Working Group decides to update the current factors based on this research, we can provide "capping" alternatives if so requested.

Table 1a
Comparison of Risk Factors
2020 RBC Formula/ 2014 Data / 2017 data

<table>
<thead>
<tr>
<th>Line</th>
<th>PRFs</th>
<th>RRFs</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) H/F</td>
<td>0.964</td>
<td>0.964</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>0.969</td>
<td>0.969</td>
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<td>(3) CA</td>
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</tr>
<tr>
<td>(4) WC</td>
<td>1.044</td>
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<td>(5) CMP</td>
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<td>0.901</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>1.668</td>
<td>1.490</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>1.130</td>
<td>1.176</td>
</tr>
<tr>
<td>(8) SL</td>
<td>0.938</td>
<td>0.949</td>
</tr>
<tr>
<td>(9) OL</td>
<td>1.013</td>
<td>1.013</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>0.879</td>
<td>0.831</td>
</tr>
<tr>
<td>(12) APD</td>
<td>0.836</td>
<td>0.836</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>0.854</td>
<td>0.680</td>
</tr>
<tr>
<td>(13) Other</td>
<td>0.935</td>
<td>0.935</td>
</tr>
<tr>
<td>(15) International</td>
<td>1.234</td>
<td>1.638</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>1.239</td>
<td>1.240</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>1.323</td>
<td>1.322</td>
</tr>
<tr>
<td>(18) PL</td>
<td>1.263</td>
<td>1.285</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>1.598</td>
<td>2.513</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>0.854</td>
<td>1.028</td>
</tr>
<tr>
<td>Average Risk Factor- all Lines</td>
<td>0.964</td>
<td>0.968</td>
</tr>
<tr>
<td>Average Risk Factor- 10-Yr Lines</td>
<td>0.996</td>
<td>0.996</td>
</tr>
<tr>
<td>Average Risk Factor- 2-Yr Lines</td>
<td>0.880</td>
<td>0.895</td>
</tr>
</tbody>
</table>

Note 1: Average Risk Factors are based on 2017 industry total net written premium and net unpaid loss and loss adjustment expense reserves, by LOB, for PRFs and RRFs, respectively.

Note 2: The company risk charge depends on not only the Risk Factors, above, but also depends on adjustments for company experience, investment income, loss sensitive contracts, company expenses (for premium risk) and a concentration adjustment. The change in Risk Factor is not representative of the change in RBC value for any particular company, as the Risk Factor does not include all elements of the RBC Formula and as distribution of premium/reserves by LOB differs widely among companies. Tables 1c-1e provide further details on the effect of the indicted Risk Factors on overall RBC values.
Note 3: Our indications are based on data from 1989–2017 Annual Statements, Schedule P Parts 1, 2 and 3 for “Ten-Year LOBs” and from 1997–2017 confidential RBC Filings for Two-Year LOBs. The NAIC compiled the data from the RBC Filings so that the available experience reflected 10 years for all LOBs.

Note 4: The shaded lines represent factors which are based on a limited amount of data.

As our data sources and methods somewhat different between Two-Year LOBs and Ten-Year LOBs, the table shows the average indicated Risk Factors for all-lines combined and, also, separately for Two-Year LOBs and Ten-Year LOBs. Ten-Year LOBs are the LOBs for which Schedule P shows 10 accident years (AYs) of data. Two-Year LOBs are those for which Schedule P shows only two AYs of data.

Table 1b, below, supplements Table 1a, showing the premium risk charges assuming industry average expenses and showing the percentage change in Premium Risk Charge percentage (PRC%) and Reserve Risk Charge percentage (RRC%). Note that the percentage change in RBC charge is higher than the change in Risk Factor as a percentage of premium or reserves.

---

8 Electronic data for Part 1 is available for some earlier years, but, for the earlier annual statement years, the LOB definitions in Schedule P were not the same as the current LOB definitions.
9 The Two-Year LOBs include Special Property, Automobile Physical Damage, Fidelity/Surety, Other (Including Credit, Accident and Health), Financial/Mortgage Guaranty, and Warranty.
10 The analysis uses less than $50 billion in 2017 NEP or less than $50 billion in 2017 reserves after filtering, using Annual Statement data for all LOBs.
11 $RC% = PRF + 2017 industry average expense ratio by LOB -100%. $RRC% = RRF. Column (4) = column (3)/column (2). Column (7) = column (6)/column (5).
### Table 1b
Comparison of Risk Factors
2020 RBC Formula/ 201 Data / 2017 data

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) H/F</td>
<td>25.4%</td>
<td>24.9%</td>
<td>-1.7%</td>
<td>21.3%</td>
<td>22.3%</td>
<td>4.5%</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>19.7%</td>
<td>20.4%</td>
<td>3.2%</td>
<td>17.9%</td>
<td>20.1%</td>
<td>12.3%</td>
</tr>
<tr>
<td>(3) CA</td>
<td>29.6%</td>
<td>30.8%</td>
<td>4.1%</td>
<td>34.8%</td>
<td>36.1%</td>
<td>3.9%</td>
</tr>
<tr>
<td>(4) WC</td>
<td>30.6%</td>
<td>29.1%</td>
<td>-4.8%</td>
<td>34.4%</td>
<td>33.5%</td>
<td>-2.5%</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>25.7%</td>
<td>25.3%</td>
<td>-1.5%</td>
<td>49.4%</td>
<td>49.9%</td>
<td>1.0%</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>74.4%</td>
<td>73.5%</td>
<td>-1.3%</td>
<td>29.6%</td>
<td>26.5%</td>
<td>-10.3%</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>43.1%</td>
<td>40.4%</td>
<td>-6.3%</td>
<td>8.9%</td>
<td>9.4%</td>
<td>5.5%</td>
</tr>
<tr>
<td>(8) SL</td>
<td>28.7%</td>
<td>29.1%</td>
<td>1.2%</td>
<td>43.1%</td>
<td>41.5%</td>
<td>-3.8%</td>
</tr>
<tr>
<td>(9) OL</td>
<td>31.6%</td>
<td>31.8%</td>
<td>0.4%</td>
<td>53.1%</td>
<td>52.7%</td>
<td>-0.8%</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>13.2%</td>
<td>13.2%</td>
<td>0.1%</td>
<td>42.8%</td>
<td>27.8%</td>
<td>-35.2%</td>
</tr>
<tr>
<td>(12) APD</td>
<td>6.8%</td>
<td>6.9%</td>
<td>2.1%</td>
<td>15.5%</td>
<td>13.2%</td>
<td>-14.7%</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>18.0%</td>
<td>16.6%</td>
<td>-8.0%</td>
<td>91.7%</td>
<td>60.0%</td>
<td>-34.5%</td>
</tr>
<tr>
<td>(13) Other</td>
<td>19.1%</td>
<td>18.9%</td>
<td>-0.9%</td>
<td>37.5%</td>
<td>22.5%</td>
<td>-40.0%</td>
</tr>
<tr>
<td>(15) International</td>
<td>107.7%</td>
<td>115.1%</td>
<td>6.9%</td>
<td>69.5%</td>
<td>104.4%</td>
<td>50.2%</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>50.7%</td>
<td>50.7%</td>
<td>0.0%</td>
<td>41.5%</td>
<td>34.3%</td>
<td>-17.3%</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>59.0%</td>
<td>52.0%</td>
<td>-11.9%</td>
<td>65.6%</td>
<td>63.6%</td>
<td>-2.9%</td>
</tr>
<tr>
<td>(18) PL</td>
<td>61.4%</td>
<td>60.0%</td>
<td>-2.4%</td>
<td>134.5%</td>
<td>147.2%</td>
<td>9.5%</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>185.4%</td>
<td>192.9%</td>
<td>4.0%</td>
<td>6.0%</td>
<td>0.1%</td>
<td>-98.2%</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>28.6%</td>
<td>23.3%</td>
<td>-18.6%</td>
<td>31.6%</td>
<td>31.2%</td>
<td>-1.3%</td>
</tr>
</tbody>
</table>

**Average Risk Factor- all Lines**
23.8% 23.8% -0.1% 38.3% 37.6% -1.9%

**Average Risk Factor- 10-Yr Lines**
26.9% 26.7% -0.5% 38.7% 39.0% 0.9%

**Average Risk Factor- 2-Yr Lines**
16.0% 16.3% 1.6% 34.4% 21.8% -36.6%

See Notes 1-4 on Table 1a

**Effect of Indicated Risk Factors on RBC by Company**

The NAIC has provided the information in Appendix 13, which summarizes the company-by-company changes in RBC values implied by the indicated RBC factors, for all companies with RBC Filings in 2019. These calculations include the effect of all elements of the RBC Formula.

Tables 1c – 1e, below, compare the RBC values based on the indicated Risk Factors with the 2017 data, in this Report, to the RBC values based on the indicated Risk Factors with the 2014 data, in the 2016 Report.

Table 1c shows that, overall, the 2017 indicated Risk Factors produce very little change in UW RBC Values for reserve risk, premium risk, or total Authorized Control Level (ACL) RBC. The average effect is a change of -0.6% for ACL.
Table 1c
Change in RBC Values
Indicated Risk Factors with 2017 Data Compared to Indications with 2014 Data

<table>
<thead>
<tr>
<th>Risk Element</th>
<th>Indicated 2017 vs. Indicated 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in Reserve Risk RBC</td>
<td>-1.5%</td>
</tr>
<tr>
<td>Change in Premium Risk RBC</td>
<td>-0.4%</td>
</tr>
<tr>
<td>Change in ACL</td>
<td>-0.6%</td>
</tr>
</tbody>
</table>

Table 1d shows that the changes, by company, are largely confined to the ±5% range.

Table 1d
Distribution of Change in ACL Values

<table>
<thead>
<tr>
<th>% Change in ACL RBC</th>
<th>From 2014 to 2017 Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than -50%</td>
<td>0</td>
</tr>
<tr>
<td>-50% to -25%</td>
<td>20</td>
</tr>
<tr>
<td>-25% to -15%</td>
<td>29</td>
</tr>
<tr>
<td>-15% to -5%</td>
<td>167</td>
</tr>
<tr>
<td>-5% to 5%</td>
<td>1,534</td>
</tr>
<tr>
<td>5% to 15%</td>
<td>85</td>
</tr>
<tr>
<td>15% to 25%</td>
<td>2</td>
</tr>
<tr>
<td>25% to 50%</td>
<td>0</td>
</tr>
<tr>
<td>Over 50%</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1,837</td>
</tr>
</tbody>
</table>

Table 1e shows the effect on RBC value by Type of Company.12

The largest change is for the Type of Company “NOC”. The LOBs that predominate for that Type of Company are Fidelity/Surety, Special Liability,13 and Other Liability. The variation in changes by Type of Company are larger for reserve risk than for premium risk. Appendix 13 contains more details on Type of Company and the distribution of LOBs within each Type of Company.

In the next section, we discuss the changes in data and methodology that influence those observations.

12 Each LOB is categorized as being typical of a particular Type of Company, e.g., Private Passenger Automobile Liability is typical of Personal Lines companies. For each company, the category with the largest amount of premium determines the Type for that company. For example, a company with more of its premium in Private Passenger Automobile Liability, Homeowners, or Automobile Physical Damage than in any of the other groups of LOBs is categorized as Personal. Appendix 13, Part 4 provides the complete definition.

13 For example, Boiler and Machinery and Ocean Marine LOBs.
Table 1e
Change in ACL Values by Type of Company
Indicated Risk Factors with 2017 Data Compared to Indications with 2014 Data

<table>
<thead>
<tr>
<th>Type of Company</th>
<th>ACL Value with 2020 Risk Charges ($Billions)</th>
<th>Indicated 2017 vs. Indicated 2014</th>
<th>Reserve Risk Charge</th>
<th>Premium Risk Charge</th>
<th>ACL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>64.9</td>
<td>-2.8%</td>
<td>-0.7%</td>
<td>-1.5%</td>
<td></td>
</tr>
<tr>
<td>Med Prof Liab</td>
<td>2.4</td>
<td>-14.9%</td>
<td>-6.9%</td>
<td>-3.0%</td>
<td></td>
</tr>
<tr>
<td>NOC</td>
<td>0.9</td>
<td>-23.0%</td>
<td>-1.7%</td>
<td>-10.8%</td>
<td></td>
</tr>
<tr>
<td>Personal</td>
<td>84.3</td>
<td>4.9%</td>
<td>0.9%</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td>Reinsurance</td>
<td>8.2</td>
<td>-4.9%</td>
<td>-3.4%</td>
<td>-0.5%</td>
<td></td>
</tr>
<tr>
<td>Workers Comp</td>
<td>10.1</td>
<td>-3.0%</td>
<td>-4.3%</td>
<td>-2.0%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>170.6</td>
<td>-1.5%</td>
<td>-0.4%</td>
<td>-0.6%</td>
<td></td>
</tr>
</tbody>
</table>

NOC = Not otherwise classified.

Elements Driving Differences Between 2017 Indicated Risk Factors and 2014 Indicated Risk Factors
The changes in indicated Risk Factors from the 2016 Report to the current Report result from additional data and from some refinements in methodology. The sections below discuss the factors driving the major changes by Type of Company.

1. Zero Interior Anomaly—RRFs
We find that in the RBC Filings, there are companies that do not complete the interior of loss triangles, perhaps because these values are not required in the RBC calculation. For these companies, in the incurred and paid development triangle of the RBC Filing, all points are zero or blank, other than (a) initial evaluations by AY on the diagonal of the triangle, and (b) current evaluations of each AY, on the last column. We refer to these as “Zero Interior” triangles. Appendix 4, Table A-5b, contains an illustration of a zero interior triangle.

For Two-Year LOBs, in this Report, we remove Zero Interior triangle data from our analysis. That is a change compared to the 2016 Report, and that is the largest source of change in indicated RRFs for Two-Year LOBs. Four of those Two-Year LOBs are typical lines for the Type of Company “NOC” which shows the largest change in reserve risk RBC value as follows: Fidelity/Surety, “Other,” Financial/Mortgage Guaranty, and Warranty.

In the 2016 Report we addressed the potential for zero interior data by excluding Reserve Runoff Ratios (RRR) with absolute value greater than 5. In this report we applied the zero interior filter in addition to excluding RRRs with absolute value greater than 5. Appendix 11, Table A-8a shows the effect of zero interior filter, by LOB.

2. Refined Minor Lines Definition—RRFs
We exclude risk data points where the premium for the LOB represents a small portion of a company’s all lines premium as defined below. We call these data points “Minor Lines.”
For Reserve Risk, the Minor Lines filter compares the NEP for the LOB for a period of years to the corresponding all-lines premium. To the extent the appropriate data are available, we use a rolling Ten-Year period for this calculation. As there are variations in the data available from year-to-year, the “window” varies by LOB. Appendix 5 provides further details on this approach.

The use of Ten-Year “windows” differs from the approach in 2016 Report, where the reserve risk Minor Lines definition was based on all-years premium. With the increase in the number of years of premium in our data set, we determined that a change in procedure should be considered, and we adopted this approach.

This change in methodology reduces RRFs by about 1% overall, but by larger amounts for the reinsurance LOBs, for Financial/Mortgage Guaranty, for Other, and for Special Property LOBs. The change drives much of the change for the reserve risk RBC values for the Reinsurance Type of Company. Appendix 11, Table A-8a shows the effect of the revised minor lines definition, by LOB.

3. Absolute (RRR)>5—RRFs—Two-Year LOBs Based on RBC Data
In the 2016 Report, we excluded RRR values greater than 5 for both Ten-Year LOBs and Two-Year LOBs from Annual Statement and RBC data, respectively, because we were concerned that the ratios reflected data quality issues.

We have reviewed this issue, and for the Two-Year LOBs from confidential RBC data, we continue to exclude data if the absolute value of RRR is greater than 5, as many such values appear to be due to data anomalies. For the Ten-Year LOBs, however, in this review, we use RRR values, regardless of size.

If large RRR values were data errors, then we might expect an impact across all LOBs. However, for Ten-Year LOBs, to the contrary, we find a wide range of impacts, as a percentage of reserves, from a low 0.000 to a high of 0.195. There are nine of thirteen Ten-Year LOBs affected by less than 1% of reserves and only two affected by more than 5% of reserves. As such, we see no need for an all-lines exclusion.

Table A-5a, in Appendix 4, below, shows the effect of removing this filter by LOB. It shows that the weighted average effect on the RRFs for Ten-Year LOBs is an increase of 0.9% of reserves. It shows the Ten-Year LOBs most affected by removing the exclusion are as follows: Products Liability (19% of reserves) and International (20% of reserves). The LOB effects are not apparent in the Type of Company summary because Products Liability is usually a small part of business for a Commercial Type of Company and International is a relatively small LOB.

The change tends to increase the indicated RRF for reinsurance liability, which mitigates the effect of other changes in RRF for that LOB, e.g., the change in the Minor Lines procedure.

4. Other Changes
We describe the nature of the changes in more detail in the remainder of the Report, and we show all the components of change in the following Appendices:

- PRFs (Ten-Year LOBs): Appendix 10, Table A-7
• RRFs (all LOBs): Appendix 11, Table A-8

Issues Related to Certain LOBs
Various considerations that might affect the selection of Risk Factors for certain LOBs are as follows:

- Low Credibility LOBs—The International, Financial/Mortgage Guaranty, and Warranty LOBs have relatively few data points for our analysis—900, 200, and 100 respectively—after filtering for reserve risk and similar amounts for premium risk. That compares to over 10,000 data points for the Private Passenger Liability, Homeowners, and Workers’ Compensation LOBs. As such, indicated Risk Factors are more subject to variation from year-to-year because of even small changes in methodology and because of random variations in emerging data, than is the case for other LOBs.

- Financial/Mortgage Guaranty—There are many single state/monoline companies that provide data in the Annual Statements, but that are exempt from RBC requirement. The data for the single state/monoline mortgage/financial guaranty companies are not included in the data used to develop the indicated Risk Factors in Table 1.14

- Warranty—This LOB was separated from the Fidelity/Surety LOB in 2008. Some companies provided a complete history for Accident Year (“AY”) including prior AYs. Other companies provided the separate data only for AYs 2008 and subsequent. As such, RBC data for the Warranty LOB in Annual Statements prior to 2017 is very limited.

- International—As noted in the first bullet, the volume of data in this LOB is relatively low. Moreover, proportionally more of the historical experience for this LOB arises from earlier Annual Statements than from more recent Annual Statements. As such, the relevance of indicated Risks Factors for current LOB M business is less certain than for other LOBs.

- Products—Asbestos and Environmental claim emergence affects reserve development from each of the over 30 years of Annual Statements in our analysis. It is possible that this ongoing emergence results in over-stated indicated RRFs.15,16

- Minimum Risk Charges—For some LOBs, the indicated risk charges will be negative, after the investment income adjustment, for a company with industry average expenses and with average loss ratio/reserve development experience (Medical Professional Claims Made and Financial/Mortgage Guaranty RRFs). Also, for one LOB, the indicated risk charge will be zero or above, but below 5%, (Automobile Physical Damage-PRF). The NAIC Working Group may want to consider the use minimum risk factors.

---

14 This RBC Risk Factor analysis does not consider the solvency risk aspects of Statutory Contingency Reserves that might be provided for Financial/Mortgage Guaranty LOBs or the implications of large unearned premium reserves (viewed as a percentage of written premium) for longer duration policies in Warranty, Financial/Mortgage, and health (included in “Other”) LOBs.

15 It is less obvious in the PRF indicated Risk Factors, but asbestos and environmental claim emergence might also affect Reinsurance Liability, Other Liability, and (to a lesser degree) Commercial Multi peril LOBs.

16 To the extent that the NAIC Working Group implements changes in risk factors with caps, as it has done in the past, this risk of over-stated Product Liability RRFs is mitigated.
Effect of 2017 Risk Factors Compared to Risk Factors in 2020 RBC Formula

If the NAIC Working Group were to implement Risk Factor changes based on the indicated Risk Factors, Table 1f, below, shows the percentage change in reserve Risk Charge, premium Risk Charge and ACL that would result, using capped and uncapped scenarios shown.

<table>
<thead>
<tr>
<th>Row</th>
<th>Risk Factors/Capping</th>
<th>% Change From 2020 Formula</th>
<th>Reserve Risk Charge</th>
<th>Premium Risk Charge</th>
<th>ACL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2020 RBC Formula</td>
<td></td>
<td>Base</td>
<td>Base</td>
<td>Base</td>
</tr>
<tr>
<td>2</td>
<td>2014 Indicated -Uncapped</td>
<td></td>
<td>9.3%</td>
<td>-1.9%</td>
<td>2.8%</td>
</tr>
<tr>
<td>3</td>
<td>2017 Indicated -Uncapped</td>
<td></td>
<td>7.6%</td>
<td>-2.3%</td>
<td>2.2%</td>
</tr>
<tr>
<td>4</td>
<td>2017 Indicated -5% Min. - Uncapped</td>
<td></td>
<td>9.0%</td>
<td>-1.1%</td>
<td>2.5%</td>
</tr>
<tr>
<td>5</td>
<td>2017 Indicated -5% Min. - ±10% Max</td>
<td></td>
<td>0.5%</td>
<td>-0.6%</td>
<td>0.0%</td>
</tr>
<tr>
<td>6</td>
<td>2017 Indicated -5% Min. - ±20% Max</td>
<td></td>
<td>2.2%</td>
<td>-1.3%</td>
<td>0.4%</td>
</tr>
<tr>
<td>7</td>
<td>2017 Indicated -5% Min. - ±35% Max</td>
<td></td>
<td>3.9%</td>
<td>-1.4%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Table 1f shows the following:

- Row 2—The change in risk charges that would result from implementing the 2014 indicated Risk Factors in the 2016 Report is not zero, because those factors have been partially, but not fully implemented.
- Row 3—The change in Risk Factors that would result from implementing the 2017 indicated Risk Factors are lower than from implementing the 2014 indicated Risk Factors, because, as shown in Table 1c, the 2017 indicated Risk Factors are lower than the 2014 indicated Risk Factors.
- Row 4—If we apply a minimum risk charge, after investment income adjustments, of 5%, the change in risk charges is slightly higher than if that were not applied, i.e., 2.5% of ACL rather than 2.2% of ACL.
- Rows 5-7—If we apply the 2017 indicated Risk Factors, but capped to produce a maximum change in risk charge by LOB, after investment income adjustment, the changes in ACL are 0.0%, 0.4%, and 0.9% for caps of 10%, 20%, and 35% respectively. The caps are applied to the absolute value of the risk charge change, i.e., no more than 10% upward or 10% downward. The 5% minimum is applied in each of the examples.

### 3. METHODOLOGY

We determine the indicated Risk Factors as outlined below in Appendices 1-9. In Appendices 10 and 11, we analyze the movement in indicated Risk Factors from the values in the 2016 Report to the values in this Report.
Risk Factor Overview
We describe the basis for the PRF and RRF indications below.

PRF Indications
The PRF for a LOB is a component of the premium risk charge, which reflects the risk that a subsequent year of company premium, net of reinsurance, will produce an adverse UW result.

The indicated PRF for each LOB is derived from loss and loss adjustment expense (“LAE”) ratios, for each LOB/company/year in the selected experience period. We refer to the net earned premium (“NEP”) and the loss ratio (“LR”) for an AY/company/LOB as a premium risk data point.

The indicated PRF is the 87.5th percentile of the LRs after the filtering described in the Data Selection section below.

RRF Indications
The RRF for a LOB is a component of the reserve risk charge, which reflects the risk that currently reported reserves for loss and all loss adjustment expense, net of reinsurance, will develop adversely from the initial reserve date to ultimate.\(^\text{17, 18}\)

The indicated RRF for each LOB is derived from RRRs by company/year in the selected experience period. The denominator of that ratio is the company carried loss reserve, for all AYs combined, at the initial reserve date.\(^\text{19}\) The numerator of the ratio is the increase/decrease in the company estimated incurred losses for all AYs combined from that initial reserve date to the latest available evaluation date. Appendix 12—Examples 1, 2, and 3 illustrate the RRR calculation. We refer to the initial reserve amount and the RRR for an initial reserve date/company/LOB as a reserve risk data point. We refer to premium and reserve risk data points, generically, as risk data points.

The indicated RRF is the 87.5th percentile of the RRRs after the filtering described below.

Data
We obtain our data from:

- Annual Statements, Schedule P, Parts 1, 2, and 3, for all LOBs, for years 1989–2017, and
- Confidential RBC Filings,\(^\text{21}\) for Two-Year LOBs, for years 1994–2017.\(^\text{22}\)

\(^\text{17}\) The development to ultimate is often referred to as a “runoff” time horizon, in contrast to a “one year” time horizon that considers adverse development over a one-year period. This is intended to be the development to ultimate, but implementation of that intention is limited by the available data.

\(^\text{18}\) The RRF does not measure the adequacy of a company’s carried reserves. The company experience adjustment, not part of this analysis, partially reflects company historical reserve adequacy, relative to the industry.

\(^\text{19}\) The amounts in this calculation are gross of nontabular discount.

\(^\text{20}\) Electronic data for Part 1 is available for some earlier years, but, for the earlier annual statement years, the LOB definitions in Schedule P were not the same as the current LOB definitions.

\(^\text{21}\) RBC Forms PC111-114 and 121-122 for premium and RBC Forms 211-214, 221-222, and 301-304, for reserves.

\(^\text{22}\) RBC Filing data compiled by regulators who provide summary results to this Committee.
Compared to the 2016 Report, the data available for this Report include three “new” Annual Statement and RBC Filings (2015–2017), and eight “older” Annual Statements (1989–1996). These additional data are desirable because they include more data points, contain more developed data for recent years, reflect a wider range of UW and economic conditions, include more recent data, and provide some data for AY 1988 and subsequent that were not available in the data used for the 2016 Report.23

Data Filtering
Consistent with the 2016 Report methodology, our indicated Risk Factors use the data described above and filtering rules itemized below. The filtering rules address the following features of the data:

1. Experience period
2. Pooling
3. Anomalous data, including Zero Interior filter
4. Minor lines
5. Age
6. Size
7. Maturity

In this analysis we refine the use of filters compared to the 2016 Report, as follows:

For both Premium and Reserve Risk:
- Enhanced the size threshold calculation (Appendix 7)
- Age based on “pool” age rather than “oldest company” age (Appendix 6)
- In the 2016 Report we selected the most mature LR and RRR after we consolidated company data into pools, as appropriate, (“Pooling First”). In this Report, we select the most mature LRs and RRRs by company, before consolidation into pools, as appropriate (“Maturity First”). (Appendix 3).

For Reserve Risk Factors:
- Revise the treatment of RRRs with absolute value greater than 5 for Ten-Year LOBs (Appendix 4)
- Revised definition of “Minor Lines” (Appendix 5)
- Zero Interior filter for reserve risk data for confidential RBC Filings, used for Two-Year LOBs, and from Annual Statement, for all LOBs (Appendix 4)
- Minor lines categorization and LOB-age for RBC RRRs based on Annual Statement data (Appendix 5—Minor Lines and Appendix 6—LOB-age)

23 For example, there are companies with 1996 Annual Statements that include data on AY 1988, or reserve year ending December 31, 1988, that did not file Annual Statements after 1996. In this case, the 1988 experience of these companies are not part of the 2016 Report analysis, because data from 1996 and prior Annual Statements were not available.
We identify the changes with the largest effects, by Type of Company, in the Findings section above.

We outline the nature of these filters, and the impact of the changes, in the sections immediately below, and we further describe them in Appendices 1-9. Except as noted, we applied the same methods in our analysis of Annual Statement data and confidential RBC data.

### 1. Experience Period (Appendix 2)

In this Report, we use LRs for AYs 1988–2017 and RRRs for initial reserve years ending 1988–2016. For Ten-Year LOBs, we obtain this data from Annual Statements. For Two-Year LOBs, we obtain the data from confidential RBC Filings. For the 2016 Report, the data covered LRs and RRRs from AY 1988–2014 and initial reserve years ending December 31, 1988–2013.

**Exclude AYs and Initial Reserve Years Prior to 1988**

For this Report, we have experience for AYs/Reserve Years 1980 to 1987 that was not available for the 2016 Report. Looking at indicated Risk Factors by decade, we find that for nearly all the liability LOBs, this oldest block of years shows the highest indicated PRFs and RRFs.

This pattern may be due to factors that might not be applicable to current conditions. For example, the 1993 Report on Reserve and Underwriting Risk Factors by the American Academy of Actuaries Property/Casualty Risk-Based Capital Task Force (page 4) identified four reasons why the experience of the 1980’s might not be suitable for projection of the future. These are:

- **The tort liability explosion, particularly in respect to asbestos and environmental liabilities.**
- **A great deal of naïve capacity, focused especially on general liability and reinsurance lines.**
- **High interest rates, creating intense pressures to engage in cash flow underwriting**
- **High inflation rates**

Other considerations include:

- Company loss reserving practices may have improved because of required actuarial opinions and increased regulatory, rating agency and management attention to reserving.
- The adverse experience in these years triggered expansion in the use of claims-made policies, pollution exclusions, asbestos exclusions, and other policy changes.
- Company pricing discipline and pricing methodology may have improved since the 1980’s.

Therefore, in this Report, we do not use the experience prior to 1988, because these early years may not be sufficiently relevant to the present conditions.

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24 Note that the most recent AY is 2017, but the most recent initial reserve date is December 2016. The most recent initial reserve year is always one year older than the most recent AY, as for the latest year, the reserve development is zero and not useful for our analysis.

2. Pooling (Appendix 3)

We combine risk data points from intercompany pool participants into a single pool-wide risk data point. Two features of the pooling process are new in this Report.

- First, in the 2016 Report we selected the most mature LR and RRR after we consolidated company data into pools, as appropriate, (“Pooling First”). In this Report, we select the most mature LRs and RRRs by company, before consolidation into pools, as appropriate (“Maturity First”). We example the reasons for this change in Appendix 3.

- Second, while we generally apply the filter to the pooled data points, we apply the new zero interior filter before pooling.

3. Anomalous values (Appendix 4)

Premium Risk

For PRFs, we exclude risk data points with anomalous values, i.e., negative values for premiums, incurred losses. We exclude zero incurred losses, as these can represent unusual financial transactions or other data anomalies.

Reserve Risk

For RRFs, we exclude the entire company/LOB/statement year data triangle, before pooling, if:

- Any calendar year\(^{26}\) has negative cumulative incurred losses, all AYs combined
- Any calendar year has negative total cumulative paid losses, all AYs combined
- Any calendar year has a negative total reserve, all AYs combined
- The interior of the development triangle is entirely zero values

Also, for both Annual Statement and RBC data, we exclude risk data points where the initial reserve is zero. In the Pooling First approach, this can have has the effect of excluding the entire company/LOB/statement year. In the Maturity First approach, even if there is a zero initial reserve at one valuation date, we might construct RRR values from data points in the statement year for other maturities that have non-zero initial reserves.

Absolute (RRR)>5

As discussed in the Findings section, we exclude RBC risk data with absolute values of RRR>5 for Two-Year LOBs. In the 2016 Report, we excluded RRR values greater than 5 for both Ten-Year LOBs and Two-Year LOBs because we were concerned that the ratios reflected data quality issues.

\(^{26}\) A calendar year in the Annual Statement or RBC development triangle is the sum of values for all AYs within a column of the data triangle. The test means examining the sum of the incurred losses over all AYs plus the prior year row, for a development column in Schedule P, Part 2, or the corresponding amounts for RBC incurred loss schedules, and similarly for paid losses in Schedule P Part 3.
4. Minor Lines (Appendix 5)

We exclude risk data points where the premium for the LOB represents a small portion of a company’s all lines premium as defined below. (“Minor Lines”)

For premium risk, the Minor Lines filter compares the LOB premium to the all-lines NEP for each AY separately. This is the same method that was used in the 2016 Report. As described in the Findings section above, for Reserve Risk, the Minor Lines filter compares the NEP for the LOB for a period of years—10 years where practical—to the corresponding all-lines premium.

For both reserve risk and premium risk, the threshold boundary for Minor Lines is as follows:

<table>
<thead>
<tr>
<th>LOBs (NAIC Code)</th>
<th>Minor Lines Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>All lines other than those listed below</td>
<td>5.0%</td>
</tr>
<tr>
<td>Other Liability and Products Liability combined</td>
<td>5.0%</td>
</tr>
<tr>
<td>Special Liability, Fidelity/Surety, Warranty</td>
<td>2.5%</td>
</tr>
<tr>
<td>International, Financial/Mortgage Guaranty</td>
<td>No Filter</td>
</tr>
</tbody>
</table>

These thresholds in Table 2 are the same as in the 2016 Report.

We determine the Minor Line status of each reserve risk data point using Annual Statement data. We apply that status to the corresponding RBC reserve risk data point.27

5. Age—Years of LOB NEP > 0 (Appendix 6)

We exclude premium and reserve risk data points where, for a particular company/LOB, there are less than five years28 of NEP greater than zero.

This is the same filter that we used in the 2016 Report, although (1) with additional years of experience, there are some “young” LOBs excluded by this age filter in the 2016 Report that are not excluded in this Report, and (2) in this Report we determined age by pool while in the 2016 Report pool age equaled the age of the oldest company within the pool. This change may have excluded some data points that had been included in the 2016 Report.

6. LOB Size (Appendix 7)

We exclude risk data points where, for a LOB, NEP (or initial reserve) is less than the 15th percentile for the AY or initial reserve year. We smooth the 15th percentile size threshold in one of several ways that we discuss in Appendix 7.

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27 This simplifies the calculation effort required of the regulatory working with the confidential RBC data.
28 Consecutive or non-consecutive years.
7. Maturity (Appendix 8)
We exclude the least mature risk data points, as we did in the 2016 Report. We exclude risk data points with maturity less than the number of years shown in Table 3 below.

Table 3—Maturity Filtering

<table>
<thead>
<tr>
<th>Line</th>
<th>PRF</th>
<th>RRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) H/F</td>
<td>na</td>
<td>3</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>na</td>
<td>3</td>
</tr>
<tr>
<td>(3) CA</td>
<td>na</td>
<td>3</td>
</tr>
<tr>
<td>(4) WC</td>
<td>na</td>
<td>4</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>na</td>
<td>5</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>na</td>
<td>5</td>
</tr>
<tr>
<td>(8) SL</td>
<td>na</td>
<td>3</td>
</tr>
<tr>
<td>(9) OL</td>
<td>na</td>
<td>4</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>(12) APD</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>(13) Other</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>(15) International</td>
<td>4</td>
<td>na</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>na</td>
<td>3</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>(18) PL</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>4</td>
<td>na</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>5</td>
<td>na</td>
</tr>
</tbody>
</table>

8. Overall Effect of Filtering
Table 4 below shows the volume of NEP/reserve used in the filtered data set compared to the total volume. This table shows that the proposed filtered data set uses most of the NEP and reserve volume available in the data, after removing anomalous data.

Table 4—Data Used in Filtered Data Set
1988–2017 AYs and Initial Reserve Years

<table>
<thead>
<tr>
<th>Item</th>
<th>PRF</th>
<th>RRF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Lines</td>
<td>10 Yr Lines</td>
</tr>
<tr>
<td>% Premium/Reserves</td>
<td>92%</td>
<td>93%</td>
</tr>
<tr>
<td>% Risk Data Points</td>
<td>52%</td>
<td>52%</td>
</tr>
</tbody>
</table>

29 Data from 1988–2017, reflecting the effect of all filtering (items 1-7).
In the 2016 Report, these ratios had similar values. For premium and reserve amounts, the all-lines ratios were 93% and 80% for premium and reserves, respectively. For number of data points, the ratios were 53% and 43% for premium and reserves, respectively.
9. Safety Level
Consistent with prior Committee reports and NAIC Working Group, decisions, the indicated Risk Factors are based on an 87.5th percentile of reserve risk data points and premium risk data points for Reserve Risk and Premium Risk, respectively, subject to the filtering discussed previously.  

4. OTHER CONSIDERATIONS AND FUTURE RESEARCH

This Report does not address the following issues:

1. Catastrophe Loss Adjustment—The indicated PRFs shown in this Report reflect the inclusion of earthquake and hurricane catastrophe losses. We have not separated the Risk Factors into the non-catastrophe and catastrophe components used in the RBC Formula.

2. Workers’ Compensation Discount—Our scope does not include estimating the effect that unwinding Workers’ Compensation tabular reserves might have on the indicated Risk Factors.

3. Line 3 Company Experience Adjustment—The RBC formula includes an adjustment for the company loss ratio for premium risk (or runoff ratio for reserve risk) in relation to the corresponding industry ratios in pages PR0017 and PR0018, lines 1, 2, and 3.

   Consistent with the proposed calibration of PRFs and RRFs, the NAIC P&C RBC Working Group should consider changes to the calculation of the industry loss ratio and/or reserve ratio (Line 1 on PR0017 and PR0018) to reflect the filtering of the Risk Factor calibration discussed above. This could include:

   ▪ Excluding risk data points when premiums (reserves) are below the 15th percentile for that AY/LOB ("Size").
   ▪ Combining risk data points from intercompany pool participants into a single pool-wide risk data point ("Pooling").
   ▪ Excluding risk data points where the NEP for the LOB represents a small portion of a company’s total NEP ("Minor Lines").
   ▪ Excluding LOB/company risk data points if there are less than five years of NEP for that LOB ("Age").
   ▪ Assess the need for change to reflect that calibration data exclude certain immature risk data points.

4. The current RBC formula structure—Our indicated Risk Factors assume the current structure of the RBC Formula. For example, while indicated UW Risk Factors vary by line of business volume, the Committee provides a single factor for each LOB.

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30 In the next report, we plan to further discuss the safety level reflecting both Line 4 safety level and the effect of the investment income offset.

31 We believe the NAIC method of developing the factors excludes anomalous data, i.e., unexpected zero or negative values.

32 Adjustment possibilities include (a) revising own-company calculation to use only the more mature risk data points, or (b) making no adjustment because the company data and industry data are at the same maturity.

33 This is one example. There are other variations in the RBC Formula.
5. As discussed earlier in the report, in the Findings section, for several LOBs, there are particular issues that might affect selected Risk Factors and/or might be the subject of future analysis.

6. The zero interior aspect of the RBC Filing data\textsuperscript{34} that we use for our calibration indicates that additional data quality assessment for past data, and/or clarification of RBC Filing requirements, might be useful. Assessment of data quality is problematic because the RBC data is confidential, and not available in detail to this Committee.

7. As we were completing this analysis, we realized that it is possible to obtain two data points from the loss triangles provided for two-year lines of business in the Annual Statement. Because it contains a reserve valued one year prior to two individual accident years provided in the triangle, it is possible to calculate a reserve risk ratio from solely the prior year row and this would provide one additional year of development.

\section{APPENDIX 1—DATA}

We obtain our data from 1989\textsuperscript{35}–2017 Annual Statements, Parts 1, 2, and 3 for all LOBs, and from 1994–2017 confidential RBC Filings for Two-Year LOBs.

Compared to the 2016 Report, the following additional data is available for this Report:

- The 2015–2017 Annual Statements and RBC Filings add three additional AYs and three initial reserve dates: AYs 2015, 2016, and 2017, and initial reserve dates December 31, 2014, 2015, and 2016. These Filings also increase the maturity of data for AYs and reserve runoff on initial reserves for 2007–2014.\textsuperscript{36}
- The eight older Annual Statements (1989–1996) provide data for additional older AYs, and initial reserve dates, i.e.:
  - AYs 1980–1987 and December 31, 1980–1987 initial reserve dates for Ten-Year LOBs, and
  - AY 1988 and December 31, 1987, initial reserve dates for Two-Year LOBs, from Annual Statements.

These additional data are desirable, because they include more data points, contain more developed data for recent years, and reflect the effects of a wider range of UW and economic conditions. Moreover, the Annual Statement Filings for years prior to 1997 provide additional data for initial

\textsuperscript{34} This issue does not relate to the quality of RBC Filing data used for RBC calculations. Rather, because our calibrations use RBC Filing data that is not used for RBC Filing calculations, some data submission

\textsuperscript{35} Electronic data for Part 1 is available for some earlier years, but, for the earlier annual statement years, the LOB definitions in Schedule P were not the same as the current LOB definitions.

\textsuperscript{36} LRs for AYs 2006–2014 in the 2016 Report were valued at ages 9, 8, …, 1, respectively. In the current report, LRs for AYs 2006–2008 are valued as of 10 years, and LRs for AYs 2009–2014 are valued at ages 9, 8, …, 4, respectively. Reserve development data are similarly more mature.
reserve years ending 1988 and subsequent, for those companies with 1988 and subsequent experience that did not file Annual Statements after 1996.  

Lines of Business  
Schedule P currently contains information on 22 LOBs.

For the RBC Formula, and in our analysis, those 22 LOBs are combined into 19 LOBs. Other Liability Claims-Made is combined with Other Liability: Occurrence, (collectively “Other Liability”) Products Liability: Claims Made is combined with Products Liability: Occurrence, (collectively “Products Liability”) and Reinsurance: Nonproportional Assumed Property is combined with Reinsurance Nonproportional Assumed Financial (collectively “Reinsurance Property”).

Two-Year and Ten-Year LOBs  
For six of the 19 LOB combinations, Schedule P contains premium and claim information on the most recent two AYs and reserve development information on prior years combined. We refer to these as “Two-Year LOBs.” These six lines are Special Property, Automobile Physical Damage, Fidelity/Surety, Other (Including Credit, Accident and Health), Financial/Mortgage Guaranty, and Warranty.

For the remaining LOBs, Schedule P contains information on the most recent 10 AYs and reserve development on prior years. We refer to these as “Ten-Year LOBs.”

Thus, in our Annual Statement data, for Ten-Year LOBs, we have AY LRs and RRRs evaluated at maturities up to 10 years, and for Two-Year LOBs, we have AY LRs and RRRs evaluated at maturities up to two years. The RRRs from Two-Year LOBs cover the development of only the most recent two calendar years, for all accident years, including those prior to the most recent two accident years.

Premium and Reserve Risk Data  
For the analysis of premium risk, for each LOB, we obtain (a) earned premium net of reinsurance, (b) incurred loss and loss adjustment expenses net of reinsurance, and (c) the related LR, for each LOB, AY, company, and annual statement year.

For the analysis of reserve risk, we obtain (a) loss and defense and cost containment expense (“DCCE”) reserves at each year end, for all AYs combined, net of reinsurance (b) the increase/decrease in reserve estimate to the latest available maturity, for all AYs combined, net of reinsurance, and (c) the ratio of (a) and (b) that we call the RRR.  

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37 For example, there are companies with 1996 Annual Statements that include data on AY 1988, or reserve year ending December 31, 1988, that did not file Annual Statements after 1996. In this case, the 1988 experience of these companies are not part of the 2016 Report analysis, because data from 1996 and prior Annual Statements were not available.

38 The LOB definitions had a major revision in the 1989 Annual Statement. There have been some changes in LOB definitions in the years from 1989 to present. As needed, in the section below, we note those that affect analysis.

39 All values gross of non-tabular discount. Reserves and payments are net of salvage and subrogation, as reported in the Annual Statement.
Note that the calibration is based on runoff of loss + DCCE, but the resulting Risk Factor is applied to loss + all LAE. This assumes that development for adjusting and other expenses follows the same pattern as loss + DCCE.

Appendix 12, Examples 1, 2, and 3 below illustrate how we calculate RRRs for Ten-Year LOBs and Two-Year LOBs, from Annual Statement data and RRRs for Two-Year LOBs from RBC Filings.

Confidential Information in RBC Filings
The RBC Filings provide incurred loss and DCCE development draw from Schedule P Part 2, for all LOBs, and paid loss and DCCE development drawn from Schedule P Part 3, for Two-Year LOBs.

The differences between Annual Statement data and confidential RBC Filing data for reserve risk, for Two-Year LOBs, include the following:

- Annual Statement Schedule P Parts 2 and 3 contains the latest two calendar years of development data. For example, the 2017 Annual Statement shows the incurred and paid values for the following:
  - AY 2017 evaluated at December 31, 2017,
  - AY 2016 evaluated at December 31, 2016, and December 31, 2016, and
  - The reserve at December 31, 2015, for accident years 2015 and prior and the change in incurred and paid values for AYs 2015 and prior (combined) in calendar year 2016 and in calendar year 2017.

- RBC data includes up to 10 individual AYs of development, over 10 calendar years, but it does not include any development information on AYs prior to those 10.
  Because RBC data does not include development information on AYs prior to year 10, the most mature runoff ratio from RBC data includes only one AY, i.e., the most mature AY, which provides maturities from one to 10.

Thus, for the most mature RRRs from Annual Statement data we have two calendar years of development for all AYs, while for RBC data we have up to 10 calendar years of development, but for only one AY. Neither type of data is as complete as the development history available for Ten-Year LOBs from the Annual Statement, which provides ten calendar years of development for all AYs.

AY Indicated Risk Factors—Annual Statement Data Compared to RBC Data
For Two-Year LOBs, we have data from Annual Statements and from RBC Filings. We calculate indicated PRFs and RRFs from each source.

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40 RBC Forms PC111-114 and 121-122 for premium and RBC Forms 211-214, 221-222, and 301-304, for reserves.
Table A-1 below shows the differences between PRF indications using Annual Statement data and PRFs indications using RBC Filing data, and the differences between RRF indications using Annual Statement data and RRF indications using RBC Filing data.

<table>
<thead>
<tr>
<th>LOB</th>
<th>Indicated PRFs</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RBC</td>
<td>A/S</td>
<td>A/S - RBC</td>
<td>RBC No. Pts</td>
<td>A/S No. Pts</td>
<td>% increase in No Pts</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>0.831</td>
<td>0.836</td>
<td>0.005</td>
<td>13,073</td>
<td>14,941</td>
<td>14%</td>
</tr>
<tr>
<td>(12) APD</td>
<td>0.837</td>
<td>0.847</td>
<td>0.010</td>
<td>13,847</td>
<td>15,121</td>
<td>9%</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>0.666</td>
<td>0.704</td>
<td>0.038</td>
<td>2,830</td>
<td>3,389</td>
<td>20%</td>
</tr>
<tr>
<td>(13) Other</td>
<td>0.933</td>
<td>0.953</td>
<td>0.020</td>
<td>2,698</td>
<td>3,083</td>
<td>14%</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>2.588</td>
<td>1.929</td>
<td>(0.659)</td>
<td>339</td>
<td>1,042</td>
<td>207%</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>0.975</td>
<td>0.902</td>
<td>(0.073)</td>
<td>134</td>
<td>182</td>
<td>36%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOB</th>
<th>Indicated RRFs</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RBC</td>
<td>A/S</td>
<td>A/S - RBC</td>
<td>RBC No. Pts</td>
<td>A/S No. Pts</td>
<td>% increase in No Pts</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>0.278</td>
<td>0.238</td>
<td>(0.040)</td>
<td>8,903</td>
<td>11,767</td>
<td>32%</td>
</tr>
<tr>
<td>(12) APD</td>
<td>0.132</td>
<td>0.163</td>
<td>0.030</td>
<td>7,508</td>
<td>11,161</td>
<td>49%</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>0.600</td>
<td>0.311</td>
<td>(0.290)</td>
<td>1,941</td>
<td>2,636</td>
<td>36%</td>
</tr>
<tr>
<td>(13) Other</td>
<td>0.225</td>
<td>0.175</td>
<td>(0.050)</td>
<td>1,886</td>
<td>2,434</td>
<td>29%</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>0.001</td>
<td>0.274</td>
<td>0.273</td>
<td>226</td>
<td>957</td>
<td>323%</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>0.312</td>
<td>0.349</td>
<td>0.037</td>
<td>76</td>
<td>144</td>
<td>89%</td>
</tr>
</tbody>
</table>

In interpreting the differences indicated Risk Factors between the Annual Statement data and RBC data, we note the following, with respect to both PRFs and RRFs:

- Warranty—This LOB was separated from the Fidelity/Surety LOB in 2008. Some companies provided a complete history for all AYs, including AYs prior to 2008. Other companies provided the separate data only for AYs 2008 and subsequent. As such, only Annual Statement 2017 and RBC Filing 2017 contains complete development and reserve runoff data, and, overall, there are too few points, i.e., under 100, to provide reliable indicated Risk Factors. Hence, variations between Annual Statement and RBC indicated Risk Factors are not surprising.

- Financial/Mortgage Guaranty—There are many single state/monoline companies that provide data in the Annual Statements, but who are exempt from RBC requirement. As they do not make RBC Filings, the experience for the single state/monoline
mortgage/financial guaranty companies is not included in the data used to develop the indicated Risk Factors in Table 1. Hence there is substantially more data in the Annual Statement data than the RBC data, and differences between Annual Statement and RBC indicated Risk Factors are not surprising.

With respect to PRFs, for the other four Two-Year LOBs, the RBC data produces lower indicated Risk Factors. We interpret this to be the effect of favorable AY LR development that is reflected in the 10-year development in the RBC Filing data but is not reflected in the two-year development in the Annual Statement data.

With respect to RRFs, the direction of the differences between the RRFs based on Annual Statement data and RRFs based on RBC data vary by LOB, and we note the following:

- The RBC data includes both favorable and unfavorable reserve development that may not reflected in the two-calendar year window reflected in the Annual Statement data.
  - For Automobile Physical Damage, it appears that the balance of favorable and unfavorable produces a lower RRF from the RBC data than from the Annual Statement data.
  - For Fidelity and Surety, it appears that adverse economic environments in the 1999–2002 period and the 2008–2009 period generate adverse development on initial reserves established at year-ends prior to those dates, but not reflected for several years after those periods.

- RBC reserve risk data includes fewer data points for all the Two-Year LOBs, and the differences are proportionally larger for some LOBs than for others. As the company-by-company RBC data is confidential, and not available to us, we have not explored that in detail.

6. APPENDIX 2—EXPERIENCE PERIOD

We have Annual Statements premium risk data for AYs 1980–2017, for most Ten-Year LOBs and 1985–2017 from RBC Filings for most Two-Year LOBs.

We have RRRs for the same starting dates, but ending in 2016.\textsuperscript{41} Because Annual Statement LOB definitions change over time, there are fewer years of experience for the Medical Professional Liability, Warranty, and Financial/Mortgage Guaranty LOBs. Table A-2, below, shows the LRs and RRRs available to us by year.

\textsuperscript{41}The most recent initial reserve year is always one year older than the most recent AY, as, for the latest year, we only have an initial estimate and no information on subsequent development.
Table A-2
LR and RRR Years From Available Data

<table>
<thead>
<tr>
<th>Source</th>
<th>Net Earned Premium and Loss Ratio Years:</th>
<th>Initial Reserve and Reserve Runoff Ratios for Years Ending Dec. 31:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Statements (Statement Years 1989-2017)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Statements Exceptions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MPL Claims Made, MPL Occurrence (Note 1)</td>
<td>1984-2017</td>
<td>1984-2016</td>
</tr>
<tr>
<td>Financial/Mortgage (Note 2)</td>
<td>1993-2017</td>
<td>1993-2016</td>
</tr>
<tr>
<td>Confidential RBC Filings (Filing Years 1994-2017)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most Two-Year LOBs (Note 4)</td>
<td>1985-2017</td>
<td>1988-2016</td>
</tr>
</tbody>
</table>

Note 1: Earliest Annual Statement or RBC Filing for the MPL LOBs – 1993
Note 2: Earliest Annual Statement for the Financial/Mortgage LOB – 1994
Note 3: Earliest Annual Statement or RBC Filing for Warranty LOB – 2008, when the Warranty LOB was separated from the Fidelity/Surety LOB. RBC Filings for some companies show the new Warranty LOB for AYs 2008 and subsequent only, while some companies show RBC data for prior AYs as well.
Note 4: We did not use data from RBC filing years 1994-1996, as data for those years was collected for information purposes only, and might be subject to learning-curve errors.

Treatment of 1980–1987 AYs/RRRs
The current data set includes 1980–1987 AYs and RRRs that were not available for prior Committee reports, nor for the DCWP for its work.

Table A-3 below shows the indicated Risk Factors by decade, 1980–1989, 1990–1999, 2000–2009, and 2010–2017. We see that, for nearly all the liability LOBs, the oldest block of years, 1980–1989, shows the highest indicated PRFs and RRFs.

Table A-4, below, shows that including the oldest years (1980–1987) in the indicated Risk Factors produces significantly higher indicated RRFs and a somewhat higher PRFs, compared to the indicated Risk Factors excluding the oldest years. RRFs increase by more than 20% for many of the larger volume lines.

Therefore, for the reasons we discuss above, in the “1. Experience Period” subsection in the Methodology section, we believe the experience prior to 1988 may not be applicable to current conditions, and we do not include it in our indicated Risk Factors.

We plan to revisit this assumption when we review Investment Income Adjustments in our next report, where we will consider the effect of interest rate changes on risk charges over the entire period.
Table A-3
Comparison of Risk Factors—
Current Indicated (2017 Data) AY/RRF 10-Year Experience Ranges

<table>
<thead>
<tr>
<th>Line</th>
<th>80-89</th>
<th>90-99</th>
<th>00-09</th>
<th>10-17 (2)</th>
<th>PRF</th>
<th>80-89</th>
<th>90-99</th>
<th>00-09</th>
<th>10-16 (2)</th>
<th>RRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) H/F</td>
<td>0.918</td>
<td>0.999</td>
<td>0.946</td>
<td>0.909</td>
<td>0.938</td>
<td>0.195</td>
<td>0.272</td>
<td>0.200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) PPA</td>
<td>1.074</td>
<td>0.969</td>
<td>0.935</td>
<td>0.959</td>
<td>0.396</td>
<td>0.165</td>
<td>0.195</td>
<td>0.246</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) CA</td>
<td>1.193</td>
<td>1.069</td>
<td>0.958</td>
<td>1.017</td>
<td>0.589</td>
<td>0.349</td>
<td>0.359</td>
<td>0.423</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) WC</td>
<td>1.198</td>
<td>1.041</td>
<td>1.042</td>
<td>0.928</td>
<td>0.536</td>
<td>0.293</td>
<td>0.382</td>
<td>0.134</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5) CMP</td>
<td>1.020</td>
<td>0.951</td>
<td>0.848</td>
<td>0.857</td>
<td>0.973</td>
<td>0.553</td>
<td>0.456</td>
<td>0.366</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>1.777</td>
<td>1.634</td>
<td>1.379</td>
<td>1.254</td>
<td>0.981</td>
<td>0.246</td>
<td>0.361</td>
<td>0.138</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>1.035</td>
<td>1.368</td>
<td>1.084</td>
<td>1.023</td>
<td>0.242</td>
<td>0.133</td>
<td>0.081</td>
<td>0.116</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8) SL</td>
<td>1.145</td>
<td>0.996</td>
<td>0.892</td>
<td>0.882</td>
<td>0.651</td>
<td>0.680</td>
<td>0.277</td>
<td>0.102</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(9) OL</td>
<td>1.634</td>
<td>1.076</td>
<td>1.016</td>
<td>0.930</td>
<td>1.612</td>
<td>0.619</td>
<td>0.521</td>
<td>0.261</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>0.722</td>
<td>0.858</td>
<td>0.797</td>
<td>0.840</td>
<td>0.252</td>
<td>0.305</td>
<td>0.246</td>
<td>0.282</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(12) APD</td>
<td>0.773</td>
<td>0.847</td>
<td>0.817</td>
<td>0.857</td>
<td>0.045</td>
<td>0.119</td>
<td>0.164</td>
<td>0.146</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>0.673</td>
<td>0.666</td>
<td>0.760</td>
<td>0.543</td>
<td>0.373</td>
<td>0.915</td>
<td>0.560</td>
<td>0.264</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(13) Other</td>
<td>0.905</td>
<td>0.947</td>
<td>0.932</td>
<td>0.903</td>
<td>0.132</td>
<td>0.239</td>
<td>0.272</td>
<td>0.119</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(15) International</td>
<td>1.708</td>
<td>1.623</td>
<td>1.675</td>
<td>1.630</td>
<td>2.489</td>
<td>2.141</td>
<td>0.460</td>
<td>0.273</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>1.363</td>
<td>1.235</td>
<td>1.268</td>
<td>1.127</td>
<td>0.732</td>
<td>0.416</td>
<td>0.314</td>
<td>0.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>1.785</td>
<td>1.328</td>
<td>1.359</td>
<td>0.903</td>
<td>1.023</td>
<td>0.658</td>
<td>0.729</td>
<td>0.060</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(18) PL</td>
<td>1.496</td>
<td>1.378</td>
<td>1.290</td>
<td>1.067</td>
<td>2.490</td>
<td>1.532</td>
<td>1.701</td>
<td>0.701</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(19) Financial / Mortgage</td>
<td>2.726</td>
<td>2.530</td>
<td>2.506</td>
<td>2.000</td>
<td>0.059</td>
<td>0.000</td>
<td>0.006</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(20) Warranty</td>
<td>0.663</td>
<td>0.937</td>
<td>0.900</td>
<td></td>
<td>0.113</td>
<td>0.508</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Average Risk Factor- all Lines: 1.524, 0.933, 0.900, 1.001, 0.780, 0.195, 0.272, 0.200
Average Risk Factor- 10-Yr Lines: 1.143, 1.023, 0.979, 0.941, 0.385, 0.400, 0.409, 0.227
Average Risk Factor- 2-Yr Lines: 0.834, 0.907, 0.877, 0.884, 0.163, 0.267, 0.212, 0.182

Notes:
2. For PRFs and RRFs the 2010–2016/2017 have limited credibility because the maturity filter excludes up to five of the latest 10 years, and because the remaining data points are less mature than the data points for any other decade.
3. Average risk factors weighted with Annual Statement premium for all LOBs, including LOBs calibrated with RBC data.
Table A-4
Comparison of Risk Factors by Experience Period
Including/Excluding 1980–1987

<table>
<thead>
<tr>
<th>Line</th>
<th>PRF 88-17</th>
<th>PRF 80-17</th>
<th>RRF 88-16</th>
<th>RRF 80-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) H/F</td>
<td>0.960</td>
<td>0.951</td>
<td>0.223</td>
<td>0.273</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>0.975</td>
<td>1.001</td>
<td>0.201</td>
<td>0.244</td>
</tr>
<tr>
<td>(3) CA</td>
<td>1.022</td>
<td>1.073</td>
<td>0.361</td>
<td>0.417</td>
</tr>
<tr>
<td>(4) WC</td>
<td>1.030</td>
<td>1.067</td>
<td>0.335</td>
<td>0.376</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>0.897</td>
<td>0.928</td>
<td>0.499</td>
<td>0.627</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>1.480</td>
<td>1.556</td>
<td>0.265</td>
<td>0.350</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>1.149</td>
<td>1.150</td>
<td>0.094</td>
<td>0.109</td>
</tr>
<tr>
<td>(8) SL</td>
<td>0.952</td>
<td>1.006</td>
<td>0.415</td>
<td>0.477</td>
</tr>
<tr>
<td>(9) OL</td>
<td>1.014</td>
<td>1.137</td>
<td>0.527</td>
<td>0.821</td>
</tr>
<tr>
<td>(10) Spec. Prop.</td>
<td>0.831</td>
<td>0.822</td>
<td>0.278</td>
<td>0.278</td>
</tr>
<tr>
<td>(12) APD</td>
<td>0.837</td>
<td>0.834</td>
<td>0.132</td>
<td>0.132</td>
</tr>
<tr>
<td>(11) Fidelity / Surety</td>
<td>0.666</td>
<td>0.676</td>
<td>0.600</td>
<td>0.600</td>
</tr>
<tr>
<td>(13) Other</td>
<td>0.933</td>
<td>0.933</td>
<td>0.225</td>
<td>0.225</td>
</tr>
<tr>
<td>(15) International</td>
<td>1.712</td>
<td>1.679</td>
<td>1.044</td>
<td>1.479</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>1.240</td>
<td>1.240</td>
<td>0.343</td>
<td>0.348</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>1.252</td>
<td>1.493</td>
<td>0.636</td>
<td>0.636</td>
</tr>
<tr>
<td>(18) PL</td>
<td>1.270</td>
<td>1.360</td>
<td>1.472</td>
<td>1.691</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>2.588</td>
<td>2.588</td>
<td>0.001</td>
<td>0.001</td>
</tr>
<tr>
<td>Average Risk Factor- all Lines</td>
<td>0.967</td>
<td>0.992</td>
<td>0.376</td>
<td>0.471</td>
</tr>
<tr>
<td>Average Risk Factor- 10-Yr Lines</td>
<td>0.995</td>
<td>1.030</td>
<td>0.390</td>
<td>0.494</td>
</tr>
<tr>
<td>Average Risk Factor- 2-Yr Lines</td>
<td>0.897</td>
<td>0.894</td>
<td>0.218</td>
<td>0.218</td>
</tr>
</tbody>
</table>

See notes to Table A-3.

7. APPENDIX 3—POOLING METHODOLOGY

Pool Mapping
In determining the indicated UW Risk Factors, we combine the data from intercompany pool participants into a single pool-wide risk data point. Alternatively, if we were to treat these interrelated risk data points as independent, the same loss ratio value (or reserve runoff ratio) would appear multiple times, reducing the apparent variability in the LR (or RRR) across companies, and distorting the indicated 87.5th percentile LR/RRR value.\(^{42}\)

\(^{42}\) See DCWP Report 6 pages 10-12, 16, and 77-80 for more details.

[https://www.casact.org/pubs/forum/13fforum/01-Report-6-RBC.pdf](https://www.casact.org/pubs/forum/13fforum/01-Report-6-RBC.pdf)
We identify intercompany pools by annual statement year using the following information, to the extent available, for each company and annual statement year:43

- NAIC group code from 2010, 2014, and 2017 analyses to identify member companies,
- Schedule P Intercompany Pooling Participation Percentage (Schedule P Part 1 Column 34),
- Schedule F Part 9 Note, and
- Notes to Financial Statements, Note 2644 (on Intercompany Pooling Arrangements).

Our current analysis includes 1984–1996 and 2015–2017 Annual Statements, which were not part of prior Academy or DCWP analysis. For the early years, 1984–1996, as we do not have the NAIC group assignments by company, we identify pool members as companies with identical or similar loss ratios across companies in combination with the oldest known NAIC group code. For the most recent years, 2015–2017, we had the 2017 NAIC group code to guide us. For 1997–2014 we make a few changes to the pool mapping based on an improved perspective on pooling, arising from the longer history of Annual Statements available to us.

Note that due to the limitations of the data and information available, our methodology is approximate, and might not necessarily identify all intercompany pooling arrangements and/or may combine some companies that are not actually pooled.45 Group identification becomes more approximate for older annual statement years. However, we believe that the elimination of multiple identical records from the data set through this adjustment, even with the approximations, improves the quality of the Risk Factor analysis.

Selection of Most Mature Data Point—Maturity First vis-à-vis Pooling First

We have multiple evaluations of each initial reserve date-RRR and AY-LR for a given LOB/company. We remove data triangles that we classify as anomalous (see Appendix 4). Then, for each LOB, for each AY/Initial reserve year, before pooling, we determine the Annual Statement that had the most mature evaluation of the AY/initial reserve year. We calculate the LR/RRR from that Annual Statement. We pooled the resulting LRs/RRRs, using the pool associated with the annual statement year from which we calculated the LR/RRR. We refer to this approach as “Maturity First.”

In prior reviews, after removing company data triangles that we classified as anomalous, we then pooled Annual Statements, where appropriate, based on the annual statement year from which the data was derived.46 After pooling, for each LOB, we determined the most recent annual statement

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43 The pool is defined separately for each statement year. For example, if two companies are in an intercompany pool for annual statement year 2013, then all data points from that annual statement year will be pooled. If the same two companies are no longer subject to intercompany pooling in 2014, the data points will not be pooled.

44 Currently Note 26. This information was in different Notes at different years in the past.

45 The pooling structure can also affect “LOB age” as we measure age based on number of years of NEP>0 for the pooled data.

46 This change is the latest in a series of refinements to the pooling calculation in the course of studies over the past 10 years, as described below.
year for each company or pool. We obtained up to 10 LRs or RRRs from that Annual Statement. We used earlier Annual Statements to obtained one LR/RRR using the most mature AY for LR and both the most mature AY and prior AYs for RRRs. We refer to this approach as “Pooling First.”

In the normal course, the Maturity First and Pooling First methods are the same. However, we find that there are companies where the most mature reading for an LR/RRR for a LOB does not appear in the expected Annual Statement. That might be because of new pool assignments, perhaps because the company was sold, the company ceased filing Annual Statements, reinsurance transactions reduced the LR/RRR data to zero, or for other reasons.

For a company subject to pooling, with the Pooling First approach, changes in pool assignment during the experience period can result in using of the same company data multiple times. Consider two companies, A and B, each with two statements (2016 and 2017) with data for each of the 10 AYs and for the prior years combined. Also suppose that A and B became part of Pool X in 2017. In the Pooling First approach, the 2017 statements for A and B are combined into a single statement for Pool X. We calculate 30 LRs (27 RRRs) for each LOB: 10 LRs (9 RRRs) for each of A, plus 10 LRs (9 RRRs) for B from statement year 2016, plus 10 LRs (9 RRRs) for Pool X from statement year 2017.

In the Maturity First approach, prior to pooling, we calculate 10 LRs (9 RRRs) for each of Companies A and B (for AYs 2008–2017, and for initial reserve years 2008–2016) from the 2017 Annual Statement and one LR/RRR from the 2016 Annual Statement (for LR/RRR 2007). These values are then pooled, resulting in 12AY LRs (11 RRRs). The 20 LRs (18 RRRs) from the 2017 Annual Statement from Company A and Company B are pooled into Pool X and the remaining two LRs/RRRs from the 2016 Annual Statement remain unpooled. Hence, the total number of data points in the final dataset is reduced from 30/27 in the Pooling First Approach to 12/11 in the current Maturity First Approach.

The difference arises because, in the Pooling First approach, Pool X is considered a new company which results in some duplication of LR/RRRs. Hence, as expected, using the Maturity First approach somewhat reduces the number of data points.

**8. APPENDIX 4—ANOMALOUS DATA**

We describe the anomalous data treatment in the Methodology Section. In this Appendix we show Tables supporting the discussion of Absolute (RRR)≥5 and Zero Interior anomalous data filters.

Prior to 2010, the pooling issue was identified, but there was no adjustment. DCWP introduced a pooling adjustment. The pooling adjustment assumed the pooling status was constant over the 1997–2010 Annual Statements available for its work. Based on that assumption, Pooling First or Maturity First were equivalent. The 2016 Report, with a longer Annual Statement history, examined the pooling history in more detail and reflected the changes in pooling from annual statement year to annual statement year. However, that analysis continued to calculate based on Pooling First approach. In this Report, with a still longer history of Annual Statements, we revised the Pooling First approach and modified the calculation as described.
**Absolute (RRR)>5**

Table A-5a, below, shows the effect, by LOB, of removing the Absolute (RRR)>5 filter. Table A-5a shows that the weighted average effect on the RRFs for Ten-Year LOBs is an increase of 2.4% of reserves, in RRFs, and there are important variations by LOB within the Ten-Year LOBs. The effect on indicated RRRs is most apparent in International (23% of reserves) and Products Liability (15% of reserves).

<table>
<thead>
<tr>
<th>Line</th>
<th>RRF - Exclude if over 500%</th>
<th>Difference</th>
<th>% value</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) H/F</td>
<td>0.221</td>
<td>0.223</td>
<td>1%</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>0.200</td>
<td>0.201</td>
<td>1%</td>
</tr>
<tr>
<td>(3) CA</td>
<td>0.361</td>
<td>0.361</td>
<td>0%</td>
</tr>
<tr>
<td>(4) WC</td>
<td>0.334</td>
<td>0.335</td>
<td>0%</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>0.494</td>
<td>0.499</td>
<td>1%</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>0.259</td>
<td>0.265</td>
<td>2%</td>
</tr>
<tr>
<td>(7) MPLC-M</td>
<td>0.090</td>
<td>0.094</td>
<td>4%</td>
</tr>
<tr>
<td>(8) SL</td>
<td>0.386</td>
<td>0.415</td>
<td>7%</td>
</tr>
<tr>
<td>(9) OL</td>
<td>0.520</td>
<td>0.527</td>
<td>1%</td>
</tr>
<tr>
<td>(15) International</td>
<td>0.850</td>
<td>1.044</td>
<td>23%</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>0.342</td>
<td>0.343</td>
<td>0%</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>0.598</td>
<td>0.636</td>
<td>6%</td>
</tr>
<tr>
<td>(18) PL</td>
<td>1.280</td>
<td>1.472</td>
<td>15%</td>
</tr>
<tr>
<td>Average Risk Factor- 10-Yr Lines</td>
<td>0.381</td>
<td>0.390</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

**“Zero Interior” Reserve Risk Data Anomalies**

As noted in the Methodology section, in our current review we exclude a LOB/Statement year if the interior of the development triangle is zero. Table A-5b below is an illustration of such data. We also observe some cases where some of, but not the entire interior of the data triangle has unexpected zero values.
With data of this type, we can calculate RRRs for individual AYs, for example, the 10-year development, for AY 2008. However, we cannot calculate RRRs for any full initial reserve year.

In the 2016 Report, we addressed this data anomaly in two ways. First, wherever possible we used the RRR based on development of the single most mature AY, row 2 that is not affected by the zero interior values. Second, we limited the impact of zero values by excluding data points where the absolute value of the RRR was greater than 500%.

In this Report, we exclude any data point where the entire interior is blank, which partly address the need for the Absolute (RRR)>500% limitation. However, we continue to exclude any data point with RRR >500%. We believe our current process has improved the identification of valid RBC data. However, there may be further steps we and/or NAIC could take to improve the data further, in future reviews.\(^\text{47}\)

The Zero Interior issue predominately relates to RBC data for Two-Year LOBs, which are discussed above. There are also a small number of companies with Ten-Year LOB Annual Statement data that present zero interiors, typically showing non-zero values in the latest diagonal but having zero/blank data for all other values, including zero/blank in the latest evaluation column. We exclude that Ten-Year LOB data.

### 9. APPENDIX 5—MINOR LINES

We exclude risk data points where the volume for a LOB represents a small portion of a company’s volume as defined below (“Minor Lines”). The DWCP research\(^\text{48}\) reported, and the 2016 Report

\(^{47}\) As the detailed data is confidential, there are limits on the extent to which this Committee can address this issue alone.

\(^{48}\) DCWP Reports 6 and 7.
agreed, that “For certain [specialty] LOBs failure to exclude the Minor Lines risk data points appears to result in PRFs that are not representative of the risks for companies writing the bulk of the industry LOB premium.”

For premium risk, similar to the 2016 Report, the Minor Lines filter calculation compares the LOB NEP to the all-lines NEP for each AY separately.

For reserve risk, the Minor Lines filter compares the LOB NEP to the all-lines NEP for a range of years, usually 10 years ending at the initial reserve date. Because the Annual Statement LOB definitions vary over time, a 10-year range is not possible for all LOBs for all initial reserve data. Hence, our approach varies somewhat by LOB. Table A-6 shows our approach for all years.

Table A-6
Reserve Risk Minor Lines Definition: Net Earned Premium Year-Ranges

<table>
<thead>
<tr>
<th>Line</th>
<th>Initial Reserve Years Ending:</th>
<th>Net Earned Premium from the following AYs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Lines</td>
<td>1998-2016</td>
<td>Rolling 10-year window ending at the initial reserve date</td>
</tr>
<tr>
<td></td>
<td>1980-1987</td>
<td>Fifteen years, 1980-1994 (Notes 1, 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data unavailable for Two-Year LOBs.</td>
</tr>
<tr>
<td>MPL Occ and CM</td>
<td>1984-1987</td>
<td>Eleven years 1984-1994 (Note 2)</td>
</tr>
<tr>
<td></td>
<td>1988-1997</td>
<td>See Most LOBs</td>
</tr>
<tr>
<td></td>
<td>1998-2016</td>
<td>See Most LOBs</td>
</tr>
<tr>
<td>Warranty</td>
<td>2007-2016</td>
<td>Rolling 10-year window ending at the initial reserve date</td>
</tr>
</tbody>
</table>

Note 1: We use a relatively long period because, in the early part of this time period, the all-lines total does not include Two-Year LOBs and overstates the ratio of LOB premium to all-lines premium.

Note 2: This table shows the methods we would apply to initial reserve years 1980-1987, but for the reasons discussed previously, we do not use those initial reserve dates in our indicated Risk Factors.

Note 3: These are the only years of available data for the Warranty LOB.

This Minor Lines approach differs from the approach in the 2016 Report, where the reserve risk Minor Lines definition was based on all-years premium. With the increase in the number of years of premium in our data set, we adopt the approach described above.

The thresholds for the LOB Minor Lines filters for both PRFs and RRFs are the same as those we used in the 2016 Report, and are as follows:

- Apply 5.0% filter for most lines with exceptions described below.

---

49 DCWP Report 6, Page 5.
50 This is determined after pooling, so changes in pooling can affect Minor Line status.
- Apply no Minor Lines exclusion for the International and Financial/Mortgage Guaranty lines of business due to the low volume in these lines.
- Apply 2.5% filter for the Special Liability, Fidelity/Surety, and Warranty lines of business, because a 5% filter for either PRFs or RRFs would exclude most premiums or initial reserves.\(^{51}\)
- Exclude risk data points where the combined Other Liability and Products Liability NEP is less than 5.0% of total NEP to avoid exclusion of too much Products Liability volume.\(^{52}\)

For RRFs, which require multiple years of premium data, we determine Minor Line status using Annual Statement data, and we apply that categorization to the RBC data. To the extent that the LOB/Company/Initial Reserve Date in the RBC data do not have a corresponding data point in the Annual Statement data,\(^{53}\) the data point is treated as a Minor Line. For PRFs, which require a single year of data, we determine Minor Line by comparing the RBC NEP by LOB/company/year to the all-lines total NEP from the Annual Statement data.

We find that the change in Minor Lines definition, from the all-year basis to the 10-year basis, decreases the indicated RRFs for nearly all LOBs. That result is consistent with (a) Minor Lines tend to have higher RRRs than non-Minor Lines, and (b) the new method better distinguishes between Minor Lines data and non-Minor Lines data.

**10. APPENDIX 6—YEARS OF LOB NEP > 0 (“LOB Age” or “Age”)**

The 2016 Report\(^{54}\) concluded that for most LOBs, PRFs and RRFs are smallest for companies with the longest experience period for a particular LOB. The 2016 Report presented an analysis of Risk Factors, by LOB by Age. The analysis in the 2016 report shows that the differential in Risk Factors by Age is most pronounced when comparing Risk Factors with a filter of Age equal to 5+ years\(^{55}\) when compared to companies with age less than 5 years. In addition, few risk data points are removed with a filter that removes Ages less than 5.

In this Report we calculate the age of the pool as the number of years of NEP>0 for the pool. In the 2016 Report, we calculated age as the maximum of the number of years of NEP>0 for any of the companies in the pool. This change somewhat reduces the number of data points after filtering.

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\(^{51}\) In addition to the other considerations, for Warranty, a 2.5% filter was chosen due limited volume of warranty experience.

\(^{52}\) Correlation between NEP for PL and OL lines, for baseline PRF data with no Minor Lines exclusion, was 0.66.

\(^{53}\) Such mismatches can occur because, there are pooling changes by Annual Statement year and the data point might derive from one Annual Statement year in the RBC data and a different Annual Statement year in the Two-Year Annual Statement data.

\(^{54}\) This conclusion is consistent with the conclusion in DCWP, in Report 6, Section 7 and DCWP Report 7, Section 7.

\(^{55}\) Consecutive or nonconsecutive years.
11. APPENDIX 7—LOB-SIZE THRESHOLDS

Our indicated Risk Factors exclude risk data points with small premium/reserve LOB size, defined as the 15th percentile of size. We exclude the risk data points with small size because the experience of these companies/pools is not representative of the experience derived from the majority of risk data points.56 We apply the size threshold analysis to the data after filtering for Minor Lines and Age, as described in the earlier Appendices.

We consider four smoothing approaches to calculating the 15th percentile, as follows: (1) 15th percentile by year without adjustment, (2) smoothed 15th percentile by year, (3) detrended 15th percentile by year, and (4) all-year 15th percentile.

**Raw and Smoothed 15th Percentile by Year**
In method 1, we select the 15th percentile by each LOB and accident/reserve year, for each company/pool as appropriate.

In method 2, to remove large discontinuities by year, we limit each point to be within 10% of the prior and subsequent years. For the first accident/reserve year (1988), we limit each point to be within 10% of the three-year average (1989–1991) and the subsequent year (1989). For the last accident/reserve year (2017/2016), we limit each point to be within 10% of the three-year average (2014–2016/2013–2015) and the prior year (2016/2015).

**Detrended 15th Percentile by Year**
We developed the third approach listed above in response to a suggestion for future research in the 2016 Report. For some LOBs, the 15th percentile size varies randomly up and down so much that even the smoothed 15th percentile had large variations in size threshold from year to year. To address that feature, we use regression to calculate the annual trend in the 15th percentile company size by year. We use this trend to adjust the LOB premium for each company for each year to a common date, 1999 for premium and 1998 for reserves. We call the result of that calculation the “Adjusted LOB Size.”

We then determine the all-year LOB 15th percentile of the Adjusted LOB Size values across all data points. We use the regression trend rate to detrend the all-year LOB 15th percentile to the historical level for each year to determine the smoothed LOB 15th percentile by year.

**Selected LOB Size Approaches**
For all RRF calculations and for PRF calculations with Annual Statement data, we select the smoothed 15th percentile method for Homeowners, Private Passenger Auto Liability, Workers’ Compensation, Special Property, and Auto Physical Damage. For Warranty, we select the all-year overall 15th percentile. For the other 13 LOBs, we select the detrended 15th percentile method.

For PRF calculations with RBC data we select the smoothed 15th percentile method for five of the six Two-Year LOBs, and for Warranty, we select the all-year overall 15th percentile.

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56 DCWP Reports 6 and 7 shows the extent to which indicated Risk Factors vary by LOB-size.
12. APPENDIX 8—MATURITY

The 2016 Report found that Risk Factors based on data grouped by age of development can increase as the age of development increases; the effect varies by LOB but is especially pronounced for LOBs such as WC and MPL-Occurrence.

The 2016 Report considered: (a) ways to adjust risk data points so that they reflected a 10 years maturity; and (b) the alternative of excluding risk data points that are not sufficiently mature. The 2016 Report used method (b). Our indicated Risk Factors are based on the same approach that was used in the 2016 Report.

Table 3, in the Methodology section, shows the maturity filters we use.

13. APPENDIX 9—ORDER OF POOLING, ANOMALIES, AND OTHER FILTERS

In this section we summarize the order in which we apply the filtering rules discussed above.

PRF Analysis from Annual Statement Data
1. Exclude AY/LOB/Company data points with negative premium or with zero or negative incurred loss amounts
2. Calculate LRs for each AY/company/LOB remaining in the data
3. Identify the data point with greatest maturity for each AY/company/LOB
4. Apply Pooling rules to combine AY/company/LOB data points, where appropriate
5. For each AY/company-pool/LOB data point we determine, and apply filters, for the following, on a pool basis:
   a. Minor Line status
   b. LOB Age
6. With the pool data, after the prior filtering, calculate size threshold by LOB/AY and identify whether the company size exceeds that threshold.
7. Apply Maturity filter.

RRF Analysis from Annual Statement or RBC Data
1. Exclude all company Annual Statement triangles with negative calendar year values or zero interior values. Also exclude potential data points with zero calendar reserves prior to the current valuation year of each Annual Statement.
2. Calculate RRRs for each initial reserve year/company/LOB from the remaining data.
3. Identify the RRR with the greatest maturity for each initial reserve year/company/LOB.
4. Apply pooling rules to company initial reserve year/company/LOB data points, where appropriate.

5. For each RRR/company-pool/LOB data point, we determine and apply filters, for the following, on pool basis:
   a. Minor Line status
   b. LOB Age

6. With the pool data, after the prior filtering, calculate size threshold by LOB/initial reserve year and identify whether the company size exceeds that threshold.

7. Apply Maturity filter.

For Two-Year LOBs, for indicated PRFs from RBC data, we determine age, maturity, and size thresholds from RBC data. We determine Minor Line status using RBC data by LOB combined with Annual Statement for all lines combined.

For Two-Year LOBs, for indicated RRFs from RBC data, we determine size thresholds from RBC data. We determine age and Minor Line status, which require matching premium information, from Annual Statement premium data. There is no maturity filter applicable to RRFs for Two-Year LOBs.

For pooled data risk data points, for both Two-Year and Ten-Year LOBs, we determine age and maturity on a pooled basis, rather than using maximum or average values by company. We also determine Minor Lines status on a pooled basis.

14. APPENDIX 10—ANALYSIS OF CHANGE IN PRFs 2014 TO 2017 FOR TEN-YEAR LOBs

In this section we show our analysis of the change in PRFs, from the results of the 2016 Report to the results in this Report, for Ten-Year LOBs. In this analysis of change, for each LOB, we begin with the results in the 2016 Report. We then calculate a series of indicated PRFs, each step applies additional changes in methodology/data from the 2016 Report to this Report. The change in indicated PRFs between steps constitutes our measure of the effect of the methodology/data change.

We believe this provides useful information on the relative effects of each change. However, the effects interact, so that if we calculate effects in a different order, then we might measure a different effect for each change. Hence, the changes should be interpreted as informative, but not definitive.

For Two-Year LOBs, developed from confidential RBC data, we did not have the detail data from the 2016 Report needed to perform a change analysis.57

57 We note that changes are small for the larger LOBs and that when the number of data points is small—e.g., Financial/Mortgage and Warranty—the movements from year to year are not unexpected.
In the subsections below we identify which of the methodology/data changes, each of which was discussed earlier in the report, is placed in each of the categories.

**Data and Maturity First**
This category covers the following:

- As we now have older Annual Statements, we have data points for AYs and initial reserve years 1988 and subsequent that were not included in our 2016 Report.
- As we discussed in the Appendix 3—Pooling Methodology, we now select the most mature data points and then combine individual companies into pools, rather than performing the calculation in the reverse order.
- Finally, with respect to data, in the normal course of an analysis update, there are changes in the NAIC database, which contains company reports as of the date that the information was extracted. In our current work, we use data extracted from the NAIC database as of the first quarter of 2019, which updates our entire data set. The 2016 Report used data extracted in 2015–2016.

**Filters**
This category covers the following:

- We implemented some changes in the way we calculate the Size filtering (Appendix 7).
- While we apply the same five-year age filter, as we have added older and newer AYs to our database, some companies that were “new” (age under five years) in the 2016 Report are not “new” in this Report.
- We based age on the pool age. In the 2016 Report age equaled the maximum age of any company in the pool. As a result, we may have excluded some data points that were included in the 2016 Report.

**Development and Recent Years**
As in every re-evaluation, there are changes due to increasing maturity of data for AYs and initial reserve years that have not yet reached maximum maturity available in our data and the addition of new AYs and initial reserve years.

**Effect of Changes**
Table A-7a—PRFs, below, shows the effect of these factors, by LOB. Table A-7b, below, shows the changes in the number of data points after each step of the analysis.

---

58 For example, we see more data from Annual Statement years and RBC years 2013 and 2014, in the 2017 data than in the 2014 data. We understand this to be because Annual Statements and RBC Filings for some companies were not included in the NAIC data when the 2014 data was downloaded.
<table>
<thead>
<tr>
<th>Line</th>
<th>2014 Indicated PRF</th>
<th>Change as a Percentage of Premium, Due to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data, Maturity</td>
<td>First Filter Development Recent Years Total Change</td>
</tr>
<tr>
<td>(1) H/F</td>
<td>0.964</td>
<td>0.2% 0.1% 0.0% -0.7% -0.4%</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>0.969</td>
<td>0.7% 0.0% 0.2% -0.2% 0.6%</td>
</tr>
<tr>
<td>(3) CA</td>
<td>1.010</td>
<td>0.6% 0.1% 0.9% -0.4% 1.2%</td>
</tr>
<tr>
<td>(4) WC</td>
<td>1.044</td>
<td>0.3% 0.1% -0.4% -1.4% -1.5%</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>0.901</td>
<td>0.2% 0.0% 0.2% -0.8% -0.4%</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>1.490</td>
<td>2.6% -3.2% -0.3% 0.0%</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>1.176</td>
<td>-0.1% -0.2% -0.6% -1.8% -2.7%</td>
</tr>
<tr>
<td>(8) SL</td>
<td>0.949</td>
<td>0.3% -0.1% 0.1% 0.0% 0.4%</td>
</tr>
<tr>
<td>(9) OL</td>
<td>1.013</td>
<td>0.5% 0.1% 0.3% -0.7% 0.1%</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>0.831</td>
<td>N/A N/A N/A N/A 0.0%</td>
</tr>
<tr>
<td>(12) APD</td>
<td>0.836</td>
<td>N/A N/A N/A N/A 0.1%</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>0.680</td>
<td>N/A N/A N/A N/A -1.4%</td>
</tr>
<tr>
<td>(13) Other</td>
<td>0.935</td>
<td>N/A N/A N/A N/A -0.2%</td>
</tr>
<tr>
<td>(15) International</td>
<td>1.638</td>
<td>7.4% 0.0% 0.0% 0.0% 7.4%</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>1.240</td>
<td>-1.2% 1.3% -0.1% 0.0%</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>1.322</td>
<td>-3.7% -3.5% 0.2% 0.0% -7.0%</td>
</tr>
<tr>
<td>(18) PL</td>
<td>1.285</td>
<td>-0.3% -2.0% 0.9% 0.0% -1.5%</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>2.513</td>
<td>N/A N/A N/A N/A 7.5%</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>1.028</td>
<td>N/A N/A N/A N/A -5.3%</td>
</tr>
<tr>
<td>Average Risk Factor - All Lines</td>
<td>0.968</td>
<td>N/A N/A N/A N/A 0.0%</td>
</tr>
<tr>
<td>Average Risk Factor - 10-Yr Lines</td>
<td>0.996</td>
<td>0.3% 0.0% 0.1% -0.6% -0.1%</td>
</tr>
<tr>
<td>Average Risk Factor - 2-Yr Lines</td>
<td>0.895</td>
<td>N/A N/A N/A N/A 0.3%</td>
</tr>
</tbody>
</table>
Table A-7b—PRFs—Analysis of Change

Number of Filtered Data Points

<table>
<thead>
<tr>
<th>Line</th>
<th>2014 Indicated PRF</th>
<th>Data, Maturity First</th>
<th>Filter Development</th>
<th>Recent Years (1)</th>
<th>Total Change</th>
<th>2017 Indicated PRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) H/F</td>
<td>11,256</td>
<td>563</td>
<td>9</td>
<td>-</td>
<td>1,070</td>
<td>1,642</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>10,904</td>
<td>556</td>
<td>(35)</td>
<td>-</td>
<td>835</td>
<td>1,356</td>
</tr>
<tr>
<td>(3) CA</td>
<td>7,589</td>
<td>472</td>
<td>(20)</td>
<td>-</td>
<td>631</td>
<td>1,083</td>
</tr>
<tr>
<td>(4) WC</td>
<td>7,931</td>
<td>416</td>
<td>(45)</td>
<td>-</td>
<td>677</td>
<td>1,048</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>8,791</td>
<td>652</td>
<td>(109)</td>
<td>-</td>
<td>731</td>
<td>1,274</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>1,112</td>
<td>31</td>
<td>135</td>
<td>-</td>
<td>-</td>
<td>166</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>3,281</td>
<td>121</td>
<td>86</td>
<td>-</td>
<td>446</td>
<td>653</td>
</tr>
<tr>
<td>(8) SL</td>
<td>2,145</td>
<td>138</td>
<td>(34)</td>
<td>-</td>
<td>126</td>
<td>230</td>
</tr>
<tr>
<td>(9) OL</td>
<td>10,951</td>
<td>585</td>
<td>(65)</td>
<td>-</td>
<td>991</td>
<td>1,511</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>10,908</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2,165</td>
</tr>
<tr>
<td>(12) APD</td>
<td>12,040</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1,807</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>2,370</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>460</td>
</tr>
<tr>
<td>(13) Other</td>
<td>2,268</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>430</td>
</tr>
<tr>
<td>(15) International</td>
<td>410</td>
<td>47</td>
<td>61</td>
<td>-</td>
<td>-</td>
<td>108</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>1,182</td>
<td>89</td>
<td>(2)</td>
<td>-</td>
<td>88</td>
<td>175</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>1,189</td>
<td>137</td>
<td>87</td>
<td>-</td>
<td>224</td>
<td>1,413</td>
</tr>
<tr>
<td>(18) PI</td>
<td>3,341</td>
<td>165</td>
<td>254</td>
<td>-</td>
<td>419</td>
<td>3,760</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>245</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>94</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>83</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>51</td>
</tr>
<tr>
<td>Data Points - All Lines</td>
<td>97,996</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>14,896</td>
</tr>
<tr>
<td>Data Points - 10-Yr Lines</td>
<td>70,082</td>
<td>3,972</td>
<td>322</td>
<td>-</td>
<td>5,595</td>
<td>9,889</td>
</tr>
<tr>
<td>Data Points - 2-Yr Lines</td>
<td>27,914</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>5,007</td>
</tr>
</tbody>
</table>

Notes: Recent Years for MPL Occ., International, Reins. Liab., and PL are zero because the maturity filter excludes accident years 2015-2017 in the analysis of change.

For all Ten-Year LOBs combined, the change in indicated PRFs from 2014 to 2017 is relatively small, -0.1% of premium.

However, there some LOBs with larger changes in indicated Risk Factors. The two Ten-Year LOBs with indicated PRF changes greater than ±5% of premium are the following:

- International PRF is increased due to the data changes.
- Reinsurance Liability PRF is reduced due to both data changes and the filter changes.
- Financial/Mortgage and Warranty LOB PRFs change by more than 5% of premium, but these are lines with limited data and the therefore more subject to variation in indicated Risk Factors due to random effects of new information and/or even small changes in methodology.
15. APPENDIX 11—ANALYSIS OF CHANGE IN RRFs 2014 TO 2017

In this section we show our analysis of the change in RRFs, for Ten-Year LOBs and Two-Year\textsuperscript{59} LOBs, comparing from the results of the 2016 Report to the results in this Report. We described the approach in Appendix 10, above.

We categorize the changes in indicated RRFs, from those in the 2016 Report to those in this Report, as follows:

1. New Minor Lines approach for reserves described in Appendix 5 (“Minor Line Filter”).
2. Other Filters including Age, LOB Size, and Maturity (“Other Filters”).
3. Updates in NAIC database\textsuperscript{60} (“New data”) and increased maturity of initial reserve years 1998-2013 (“New Data (< 2014), Development”).
5. New quality control test to remove triangles whose entire interior is blank, Zero Interior filter.
6. Calculate RRR values by company, and select the most mature company data point, before pooling (“Maturity First”).
7. Allow $|RRR|>500\%$ for Ten-Year LOBs (“Allow $|RRR|>500\%$”).

Table A-8a—RRFs shows the effects of each of these factors, by LOB. Table A-8b, below, shows the changes in the number of data points after each step of the analysis.

\textsuperscript{59} We were able to analyze the drivers of change in RRFs from RBC data, as the regulator working with our committee recreated, under our direction, the 2016 analysis, which enabled us to analyze the drivers of change for both Ten-Year and Two-Year LOBs.

\textsuperscript{60} As expected, we see additional data for Annual Statement Years 2013 and 2014. Also, for LOB “Other,” in addition to the expected changes due to updates, we observed a significant reduction in the number of data points in the 2001 Annual Statement Year. That might have been an error in the prior analysis.
### Table A-8a—RRFs—Analysis of Change

**Indicated Risk Factors based on 2014 data to indications based on 2017 data**

<table>
<thead>
<tr>
<th>Line</th>
<th>2014 Indicated RRF</th>
<th>Change as a Percentage of Reserves, Due to:</th>
<th>2017 Indicated RRF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014</td>
<td>Minor Line RRF</td>
<td>Other Filters</td>
</tr>
<tr>
<td>(1) H/F</td>
<td>0.213</td>
<td>-0.4%</td>
<td>-0.9%</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>0.179</td>
<td>0.3%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>(3) CA</td>
<td>0.348</td>
<td>-1.1%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>(4) WC</td>
<td>0.344</td>
<td>-0.5%</td>
<td>0.3%</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>0.494</td>
<td>-1.1%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>0.296</td>
<td>-1.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>(7) MPLC-M</td>
<td>0.089</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>(8) SL</td>
<td>0.431</td>
<td>-0.5%</td>
<td>0.0%</td>
</tr>
<tr>
<td>(9) OL</td>
<td>0.531</td>
<td>-1.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>0.428</td>
<td>-4.1%</td>
<td>1.2%</td>
</tr>
<tr>
<td>(12) APD</td>
<td>0.155</td>
<td>0.9%</td>
<td>0.4%</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>0.917</td>
<td>-1.7%</td>
<td>5.7%</td>
</tr>
<tr>
<td>(13) Other</td>
<td>0.375</td>
<td>-5.7%</td>
<td>5.4%</td>
</tr>
<tr>
<td>(15) International</td>
<td>0.666</td>
<td>-0.6%</td>
<td>26.7%</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>0.415</td>
<td>-6.6%</td>
<td>0.2%</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>0.656</td>
<td>-4.7%</td>
<td>0.6%</td>
</tr>
<tr>
<td>(18) PL</td>
<td>1.345</td>
<td>-3.9%</td>
<td>2.8%</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>0.060</td>
<td>-3.7%</td>
<td>-2.3%</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>0.316</td>
<td>33.2%</td>
<td>-4.7%</td>
</tr>
<tr>
<td>Average Risk Factor - All Lines</td>
<td>0.383</td>
<td>-1.1%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Average Risk Factor - 10-Yr Lines</td>
<td>0.367</td>
<td>-1.0%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Average Risk Factor - 2-Yr Lines</td>
<td>0.344</td>
<td>-3.2%</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

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### Table A-8b—RRFs—Analysis of Change

#### Number of Filtered Data Points

<table>
<thead>
<tr>
<th>Line</th>
<th>2014 Indicated RRF</th>
<th>Minor Line Filter</th>
<th>Other Filters</th>
<th>New Data (&lt;2014), Development</th>
<th>Recent Years (2014-17)</th>
<th>Zero Interior (&gt;500%)</th>
<th>Maturity First</th>
<th>Allow [RRR] &gt;500%</th>
<th>Total Change</th>
<th>2017 Indicated RRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) H/F</td>
<td>11,258</td>
<td>51</td>
<td>(516)</td>
<td>660</td>
<td>748</td>
<td>21</td>
<td>(380)</td>
<td>20</td>
<td>604</td>
<td>11,862</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>11,620</td>
<td>105</td>
<td>(709)</td>
<td>619</td>
<td>637</td>
<td>(3)</td>
<td>(456)</td>
<td>13</td>
<td>206</td>
<td>11,826</td>
</tr>
<tr>
<td>(3) CA</td>
<td>8,222</td>
<td>(115)</td>
<td>(548)</td>
<td>503</td>
<td>431</td>
<td>9</td>
<td>(254)</td>
<td>4</td>
<td>36</td>
<td>8,262</td>
</tr>
<tr>
<td>(4) WC</td>
<td>8,087</td>
<td>60</td>
<td>(586)</td>
<td>682</td>
<td>224</td>
<td>18</td>
<td>(225)</td>
<td>2</td>
<td>175</td>
<td>8,262</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>8,322</td>
<td>(91)</td>
<td>(496)</td>
<td>956</td>
<td>-</td>
<td>12</td>
<td>(212)</td>
<td>16</td>
<td>185</td>
<td>8,507</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>1,271</td>
<td>(94)</td>
<td>(30)</td>
<td>136</td>
<td>60</td>
<td>-</td>
<td>35</td>
<td>4</td>
<td>111</td>
<td>1,382</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>2,493</td>
<td>(26)</td>
<td>(39)</td>
<td>525</td>
<td>-</td>
<td>-</td>
<td>11</td>
<td>7</td>
<td>478</td>
<td>2,971</td>
</tr>
<tr>
<td>(8) SL</td>
<td>2,215</td>
<td>155</td>
<td>(77)</td>
<td>128</td>
<td>106</td>
<td>(3)</td>
<td>(28)</td>
<td>22</td>
<td>303</td>
<td>2,518</td>
</tr>
<tr>
<td>(9) OL</td>
<td>10,568</td>
<td>(295)</td>
<td>(395)</td>
<td>956</td>
<td>336</td>
<td>(2)</td>
<td>(16)</td>
<td>20</td>
<td>604</td>
<td>11,172</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>8,499</td>
<td>(477)</td>
<td>(250)</td>
<td>469</td>
<td>607</td>
<td>137</td>
<td>(82)</td>
<td>-</td>
<td>404</td>
<td>8,903</td>
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<tr>
<td>(12) APD</td>
<td>6,620</td>
<td>(15)</td>
<td>(366)</td>
<td>403</td>
<td>358</td>
<td>278</td>
<td>230</td>
<td>-</td>
<td>888</td>
<td>7,508</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>1,971</td>
<td>172</td>
<td>(362)</td>
<td>31</td>
<td>172</td>
<td>(20)</td>
<td>(23)</td>
<td>-</td>
<td>(30)</td>
<td>1,941</td>
</tr>
<tr>
<td>(13) Other</td>
<td>1,756</td>
<td>122</td>
<td>(307)</td>
<td>133</td>
<td>124</td>
<td>1</td>
<td>57</td>
<td>-</td>
<td>130</td>
<td>1,886</td>
</tr>
<tr>
<td>(15) International</td>
<td>580</td>
<td>(21)</td>
<td>(137)</td>
<td>76</td>
<td>43</td>
<td>(1)</td>
<td>77</td>
<td>40</td>
<td>351</td>
<td>931</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>1,222</td>
<td>105</td>
<td>(70)</td>
<td>18</td>
<td>65</td>
<td>-</td>
<td>32</td>
<td>7</td>
<td>157</td>
<td>1,379</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>1,348</td>
<td>65</td>
<td>(20)</td>
<td>74</td>
<td>35</td>
<td>1</td>
<td>52</td>
<td>11</td>
<td>218</td>
<td>1,566</td>
</tr>
<tr>
<td>(18) PL</td>
<td>4,196</td>
<td>(57)</td>
<td>(156)</td>
<td>328</td>
<td>116</td>
<td>(4)</td>
<td>(62)</td>
<td>106</td>
<td>271</td>
<td>4,467</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>258</td>
<td>(33)</td>
<td>(37)</td>
<td>5</td>
<td>19</td>
<td>2</td>
<td>22</td>
<td>-</td>
<td>(32)</td>
<td>226</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>49</td>
<td>(7)</td>
<td>(12)</td>
<td>(3)</td>
<td>19</td>
<td>9</td>
<td>(23)</td>
<td>-</td>
<td>7</td>
<td>76</td>
</tr>
<tr>
<td>Average Risk Factor - All Lines</td>
<td>90,585</td>
<td>(396)</td>
<td>(4,815)</td>
<td>6,689</td>
<td>4,100</td>
<td>455</td>
<td>(1,255)</td>
<td>272</td>
<td>5,066</td>
<td>95,645</td>
</tr>
<tr>
<td>Average Risk Factor - 10-Yr Lines</td>
<td>71,412</td>
<td>(158)</td>
<td>(3,505)</td>
<td>5,661</td>
<td>2,801</td>
<td>48</td>
<td>(1,426)</td>
<td>272</td>
<td>3,693</td>
<td>75,105</td>
</tr>
<tr>
<td>Average Risk Factor - 2-Yr Lines</td>
<td>19,173</td>
<td>(238)</td>
<td>(1,310)</td>
<td>1,028</td>
<td>1,299</td>
<td>407</td>
<td>181</td>
<td>-</td>
<td>1,367</td>
<td>20,540</td>
</tr>
</tbody>
</table>

#### Change in Number of Filtered Data Points Resulting From:

<table>
<thead>
<tr>
<th>Change</th>
<th>2014 Indicated RRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Recent Years for CMP and MPL C-M are zero due because the maturity filter excludes initial reserve years 2014–2016 in the analysis of change.</td>
<td></td>
</tr>
<tr>
<td>(2) The effect shown in this column is the net result of several filters. First, prior to the impact of other filters, applying the zero interior filter caused data points to reduce in all lines. However, some number of RRRs from RBC triangles with zero interiors, have already been removed due to RRR&gt;5 filter, so the net decrease in number of RRRs is less than the decrease due to the zero interior filter alone. Moreover, when we remove the RBC triangles with zero interior values, then to the extent that there are RBC triangles from later, less mature, valuations, unaffected by zero interior values, we use those triangles. The combined effect of those factors can produce an increase in RRRs.</td>
<td></td>
</tr>
</tbody>
</table>

For all Ten-Year LOBs combined, the change in indicated RRFs from 2014 to 2017 is 0.4% of reserves. However, there some Ten-Year LOBs with larger changes in indicated Risk Factors. The three LOBs with indicated RRF changes greater than ±5% of reserves are the following:

- The International indicated RRF increased by 34.9% overall due to Other Filters (company age) and allowing RRRs greater than 500%. International is one of the three smallest lines of business both in terms of company data points included in the analysis and reserve volume. Its sensitivity to the changes is not surprising.
- The Reinsurance Prop./Fin. indicated RRF decreased 7.2% of reserves, due primarily to changes in the Minor Line filter and the addition of recent years.
- The Products Liability indicated RRF increased 12.8% of reserves due primarily to the impact of allowing RRRs greater than 500%.
For all Two-Year LOBs combined, the change in indicated RRFs from 2014 to 2017 is more significant than the Ten-Year LOBs, at -12.6%. This was driven by the new zero interior filter. With the exception of automobile physical damage, all of the Two-Year LOBs had changes greater than ±5% of reserves.

16. APPENDIX 12—EXAMPLES

Example 1: Reserve Runoff Ratio—Ten-Year LOBs—Annual Statement Data

In this section, we show how the RRRs are calculated from Annual Statement data for Ten-Year LOBs.

To illustrate the runoff ratio calculation based on Annual Statement data, consider the following simulated example, Company XYZ’s Schedule P, Part 2 and 3 for a particular LOB for Annual Statement Year 2017.

Table A-9a
Simulated Company XYZ Schedule P—Part 2

<table>
<thead>
<tr>
<th>Years in Which Losses Were Incurred</th>
<th>One Year</th>
<th>Two Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior</td>
<td>710</td>
<td>510</td>
</tr>
<tr>
<td>2009</td>
<td>3,750</td>
<td>3,700</td>
</tr>
<tr>
<td>2010</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>2011</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>2012</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>2013</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>2014</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>2015</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>2016</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>2017</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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We calculate nine RRRs from these data. The most mature is the RRR for the 2008 initial reserve year. The numerator of the Reserve Runoff Ratio is the incurred development for 2008 and prior AYs, combined, from the 2008 evaluation year to the 2017 evaluation year. These data come from Schedule P, Part 2 and we calculate this from the numbers in bold above as follows:

\[(440 + 3,620) - (730 + 4,890) = -1,560\]

The denominator of this ratio is the carried loss reserves at the 2008 evaluation date. We calculate this for all AYs combined using Schedule P, Parts 2 and 3, from the cells that are shaded above as follows:

\[(730 + 4,890) - (0 + 2,100) = 3,520\]

The value for Prior AYs in calendar year 2008 is zero because the Prior rows in Parts 2 and 3 of Schedule P are the amounts excluding the amounts paid through December 31, 2008, on AYs 2008 and prior.

The reserve runoff ratio is then simply the numerator divided by the denominator:

\[-1,560 \div 3,520 = -44.3\%\]

The reserve runoff ratios for reserve years 2009 through 2016 are calculated in the same manner.

<table>
<thead>
<tr>
<th>Years in Which Losses Were Incurred</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>Number of Claims Closed With Loss</th>
<th>Number of Claims Closed Without Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Prior</td>
<td>390</td>
<td>450</td>
<td>440</td>
<td>440</td>
<td>440</td>
<td>440</td>
<td>440</td>
<td>440</td>
<td>440</td>
<td>430</td>
<td>1,110</td>
<td>170</td>
</tr>
<tr>
<td>3 2009</td>
<td>1,540</td>
<td>2,770</td>
<td>3,350</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>610</td>
<td>100</td>
</tr>
<tr>
<td>4 2010</td>
<td>1,540</td>
<td>2,770</td>
<td>3,350</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>610</td>
<td>100</td>
</tr>
<tr>
<td>5 2011</td>
<td>1,540</td>
<td>2,770</td>
<td>3,350</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>610</td>
<td>100</td>
</tr>
<tr>
<td>6 2012</td>
<td>1,540</td>
<td>2,770</td>
<td>3,350</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>610</td>
<td>100</td>
</tr>
<tr>
<td>7 2013</td>
<td>1,540</td>
<td>2,770</td>
<td>3,350</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>610</td>
<td>100</td>
</tr>
<tr>
<td>8 2014</td>
<td>1,540</td>
<td>2,770</td>
<td>3,350</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>610</td>
<td>100</td>
</tr>
<tr>
<td>9 2015</td>
<td>1,540</td>
<td>2,770</td>
<td>3,350</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>610</td>
<td>100</td>
</tr>
<tr>
<td>10 2016</td>
<td>1,540</td>
<td>2,770</td>
<td>3,350</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>610</td>
<td>100</td>
</tr>
<tr>
<td>11 2017</td>
<td>1,540</td>
<td>2,770</td>
<td>3,350</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>3,620</td>
<td>610</td>
<td>100</td>
</tr>
</tbody>
</table>
Example 2: Reserve Runoff Ratio—Two-Year LOBs—Annual Statement Data

While our indicated RRFs for Two-Years LOBs is based on data from confidential RBC Filings, for comparison purposes, we also calculate indicated RRFs based on Annual Statement data.

The RRR calculation for Two-Year LOBs from Annual Statement data is similar to the calculation for Ten-Year LOBs, but the calculation includes only two AY and the prior year data. The following example from a 2017 Annual Statement illustrates the runoff ratio calculation based on Annual Statement data for sample Company XYZ Schedule P, Part 2 and 3.

<table>
<thead>
<tr>
<th>Table A10a</th>
<th>Simulated Company XYZ Schedule P—Part 2—Two-Year LOBs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior</td>
<td>XXX</td>
</tr>
<tr>
<td>2016</td>
<td>XXX</td>
</tr>
<tr>
<td>2017</td>
<td>XXX</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table A10b</th>
<th>Simulated Company XYZ Schedule P—Part 3—Two-Year LOBs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior</td>
<td>XXX</td>
</tr>
<tr>
<td>2016</td>
<td>XXX</td>
</tr>
<tr>
<td>2017</td>
<td>XXX</td>
</tr>
</tbody>
</table>

We calculate only one runoff ratio from these data, the runoff ratio for the 2016 reserve year. For this ratio, the numerator of the Reserve Runoff Ratio is the incurred development for 2016 and prior AYs, combined, from 2016 evaluation year to the 2017 evaluation year. These data come from Schedule P, Part 2 and we calculate this as follows:

\[(18,326 + 24,070) – (17,703 + 23,314) = 1,379\]

The denominator is the carried loss reserves at the 2016 evaluation date. We calculate this for all AYs combined using Schedule P, Parts 2 and 3, as follows:

\[(17,703+23,314) – (9,253 + 4,060) = 27,704\]
The reserve runoff ratio is then simply the numerator divided by the denominator:

$$\frac{1,379}{27,704} = 5.0\%.$$ 

**Example 3: Reserve Runoff Ratio—Two-Year LOBs—RBC Data**

The tables below show an example of RBC data. This data is the RBC data that is consistent with the Two-Year Annual Statement data shown in Example 2, above.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>2008</td>
<td>1,875</td>
<td>1,808</td>
<td>1,678</td>
<td>1,463</td>
<td>1,338</td>
<td>1,179</td>
<td>1,182</td>
<td>1,216</td>
<td>1,231</td>
<td>1,231</td>
</tr>
<tr>
<td>2009</td>
<td>1,520</td>
<td>1,827</td>
<td>1,481</td>
<td>1,388</td>
<td>1,446</td>
<td>1,276</td>
<td>1,290</td>
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</tr>
<tr>
<td>2010</td>
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<td>3,048</td>
<td>3,042</td>
<td>2,947</td>
<td>2,947</td>
<td>2,965</td>
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</tr>
<tr>
<td>2011</td>
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<td>8,902</td>
<td>8,128</td>
<td>7,351</td>
<td>7,394</td>
<td>7,855</td>
<td>7,393</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2012</td>
<td></td>
<td>8,010</td>
<td>9,881</td>
<td>9,571</td>
<td>9,435</td>
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</tr>
<tr>
<td>2013</td>
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<td></td>
<td>9,751</td>
<td>10,222</td>
<td>9,959</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
<td></td>
<td>11,581</td>
<td>12,426</td>
<td>18,731</td>
<td>18,535</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>14,533</td>
<td>16,738</td>
<td>18,086</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>23,314</td>
<td>24,070</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The RBC data differs from the Annual Statement data in that there is no data in the Prior row.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
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<td>2008</td>
<td>673</td>
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<td>966</td>
<td>997</td>
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<td>1,106</td>
<td>1,158</td>
<td>1,202</td>
<td>1,233</td>
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</tr>
<tr>
<td>2009</td>
<td>111</td>
<td>488</td>
<td>779</td>
<td>997</td>
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<td>1,156</td>
<td>1,197</td>
<td>1,201</td>
<td>1,203</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>99</td>
<td>815</td>
<td>1,937</td>
<td>2,238</td>
<td>2,451</td>
<td>2,614</td>
<td>2,811</td>
<td>2,802</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>557</td>
<td>3,939</td>
<td>5,020</td>
<td>5,447</td>
<td>6,165</td>
<td>6,242</td>
<td>6,316</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>2,332</td>
<td>4,315</td>
<td>5,024</td>
<td>7,900</td>
<td>8,656</td>
<td>8,848</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td></td>
<td>3,497</td>
<td>8,841</td>
<td>9,374</td>
<td>9,535</td>
<td>9,660</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
<td>3,112</td>
<td>8,533</td>
<td>12,387</td>
<td>14,464</td>
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</tr>
<tr>
<td>2015</td>
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<td></td>
<td>1,888</td>
<td>6,049</td>
<td>9,848</td>
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<td></td>
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<td></td>
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<tr>
<td>2016</td>
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<td></td>
<td>4,090</td>
<td>12,442</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
We calculate RRRs using the most mature runoff data available. Often that was age 10, corresponding to 2008 and prior. One feature of that calculation is that the runoff contains only one AY.

For example, the runoff for initial reserve year 2008 would be calculated as follows:

Inurred Movement = 1,231 – 1,875 = -645, using the “2008 row”.
The initial reserve = 1,875 – 92 = 1,783
The runoff ratio equals -645 ÷ 1,783 = -36.1%

Because there is no prior row, this constitutes the development of 2008 only.
# 17. APPENDIX 13—IMPACT OF ALTERNATIVE RISK FACTORS

## Part 1: Change in P&C RBC Charges by Type of Company: R4 Alone, R5 Alone, and Total ACL

<table>
<thead>
<tr>
<th>R4 charge - Reserve Risk</th>
<th>Company Category</th>
<th>Commercial</th>
<th>Med Mal</th>
<th>NOC</th>
<th>Personal</th>
<th>Reinsurer</th>
<th>Workers Comp</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total R4 Charge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020 RBC Formula</td>
<td>76.3</td>
<td>2.3</td>
<td>0.6</td>
<td>26.8</td>
<td>3.1</td>
<td>12.3</td>
<td>123.4</td>
<td></td>
</tr>
<tr>
<td>Indicated (2014 Uncapped)</td>
<td>89.0</td>
<td>0.7</td>
<td>1.1</td>
<td>27.6</td>
<td>3.3</td>
<td>13.2</td>
<td>134.9</td>
<td></td>
</tr>
<tr>
<td>Percentage change</td>
<td>13.7%</td>
<td>-70.1%</td>
<td>85.3%</td>
<td>3.1%</td>
<td>6.0%</td>
<td>7.7%</td>
<td>9.3%</td>
<td></td>
</tr>
<tr>
<td>Indicated (2017 Uncapped)</td>
<td>86.5</td>
<td>0.6</td>
<td>0.8</td>
<td>29.0</td>
<td>3.1</td>
<td>12.8</td>
<td>132.8</td>
<td></td>
</tr>
<tr>
<td>Percentage change</td>
<td>10.4%</td>
<td>-74.5%</td>
<td>42.6%</td>
<td>8.1%</td>
<td>0.8%</td>
<td>4.4%</td>
<td>7.6%</td>
<td></td>
</tr>
<tr>
<td>Indicated (2017 Min 10%)</td>
<td>86.8</td>
<td>1.7</td>
<td>0.8</td>
<td>29.2</td>
<td>3.1</td>
<td>12.8</td>
<td>134.5</td>
<td></td>
</tr>
<tr>
<td>Percentage change</td>
<td>10.9%</td>
<td>-27.5%</td>
<td>43.0%</td>
<td>9.0%</td>
<td>0.7%</td>
<td>4.3%</td>
<td>9.0%</td>
<td></td>
</tr>
<tr>
<td>Indicated (2017 Max chg 30%)</td>
<td>76.7</td>
<td>2.1</td>
<td>0.6</td>
<td>27.6</td>
<td>3.0</td>
<td>11.9</td>
<td>124.1</td>
<td></td>
</tr>
<tr>
<td>Percentage change</td>
<td>0.6%</td>
<td>-8.9%</td>
<td>5.1%</td>
<td>3.1%</td>
<td>-3.7%</td>
<td>-2.8%</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td>Indicated (2017 Max chg 20%)</td>
<td>80.1</td>
<td>1.9</td>
<td>0.6</td>
<td>28.5</td>
<td>3.0</td>
<td>12.5</td>
<td>126.2</td>
<td></td>
</tr>
<tr>
<td>Percentage change</td>
<td>2.3%</td>
<td>-17.9%</td>
<td>10.1%</td>
<td>6.2%</td>
<td>-4.4%</td>
<td>-1.7%</td>
<td>2.2%</td>
<td></td>
</tr>
<tr>
<td>Indicated (2017 Max chg 15%)</td>
<td>81.8</td>
<td>1.8</td>
<td>0.7</td>
<td>28.7</td>
<td>3.0</td>
<td>12.3</td>
<td>128.2</td>
<td></td>
</tr>
<tr>
<td>Percentage change</td>
<td>4.5%</td>
<td>-23.0%</td>
<td>17.8%</td>
<td>7.2%</td>
<td>-4.2%</td>
<td>-0.3%</td>
<td>3.9%</td>
<td></td>
</tr>
</tbody>
</table>

| Total R5 Charge        |                 |            |        |     |          |           |              |       |
| 2020 RBC Formula       | 33.9            | 1.5        | 0.7    | 32.1| 0.7      | 5.5       | 74.4         |       |
| Indicated (2014 Uncapped) | 32.6          | 1.5        | 0.6    | 31.9| 0.8      | 5.5       | 72.9         |       |
| Percentage change      | -3.7%          | -17.1%     | -16.6% | -0.5%| 7.3%     | -1.9%     | 9.3%         |       |
| Indicated (2017 Uncapped) | 32.4          | 1.4        | 0.6    | 32.2| 0.8      | 5.2       | 72.6         |       |
| Percentage change      | -4.5%          | -4.4%      | -18.0% | 0.5%| 3.6%     | -4.2%     | -2.3%        |       |
| Indicated (2017 Min 10%) | 33.2          | 1.4        | 0.6    | 32.3| 0.8      | 5.3       | 73.6         |       |
| Percentage change      | -2.0%          | -4.4%      | -17.9% | 0.8%| -4.4%    | -3.9%     | -1.1%        |       |
| Indicated (2017 Max chg 30%) | 33.4          | 1.5        | 0.7    | 32.4| 0.7      | 5.2       | 73.9         |       |
| Percentage change      | -1.4%          | -1.0%      | -1.9%  | 0.9%| -2.0%    | -4.2%     | -0.6%        |       |
| Indicated (2017 Max chg 20%) | 33.0          | 1.5        | 0.7    | 32.3| 0.7      | 5.2       | 73.4         |       |
| Percentage change      | -2.5%          | -4.4%      | -9.9%  | 0.6%| -1.4%    | -4.3%     | -1.4%        |       |
| Indicated (2017 Max chg 15%) | 33.0          | 1.4        | 0.6    | 32.3| 0.7      | 5.2       | 73.3         |       |
| Percentage change      | -2.5%          | -4.4%      | -9.9%  | 0.6%| -1.4%    | -4.3%     | -1.4%        |       |

<table>
<thead>
<tr>
<th>R5 charge - Premium Risk</th>
<th>Company Category</th>
<th>Commercial</th>
<th>Med Mal</th>
<th>NOC</th>
<th>Personal</th>
<th>Reinsurer</th>
<th>Workers Comp</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total R5 Charge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020 RBC Formula</td>
<td>64.9</td>
<td>2.4</td>
<td>0.9</td>
<td>84.3</td>
<td>8.2</td>
<td>10.1</td>
<td>170.6</td>
<td></td>
</tr>
<tr>
<td>Indicated (2014 Uncapped)</td>
<td>69.2</td>
<td>2.0</td>
<td>1.0</td>
<td>84.5</td>
<td>8.2</td>
<td>10.5</td>
<td>175.4</td>
<td></td>
</tr>
<tr>
<td>Percentage change</td>
<td>6.6%</td>
<td>-17.1%</td>
<td>20.7%</td>
<td>0.3%</td>
<td>0.6%</td>
<td>3.9%</td>
<td>2.8%</td>
<td></td>
</tr>
<tr>
<td>Indicated (2017 Uncapped)</td>
<td>68.2</td>
<td>1.9</td>
<td>0.9</td>
<td>84.9</td>
<td>8.2</td>
<td>10.3</td>
<td>174.4</td>
<td></td>
</tr>
<tr>
<td>Percentage change</td>
<td>5.1%</td>
<td>-19.5%</td>
<td>7.7%</td>
<td>0.8%</td>
<td>0.1%</td>
<td>1.8%</td>
<td>2.2%</td>
<td></td>
</tr>
<tr>
<td>Indicated (2017 Min 10%)</td>
<td>68.5</td>
<td>2.1</td>
<td>0.9</td>
<td>85.0</td>
<td>8.2</td>
<td>10.3</td>
<td>175.0</td>
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</tr>
<tr>
<td>Percentage change</td>
<td>5.5%</td>
<td>-9.7%</td>
<td>7.8%</td>
<td>0.8%</td>
<td>0.1%</td>
<td>1.8%</td>
<td>2.5%</td>
<td></td>
</tr>
<tr>
<td>Indicated (2017 Max chg 30%)</td>
<td>64.9</td>
<td>2.3</td>
<td>0.9</td>
<td>84.5</td>
<td>8.1</td>
<td>10.0</td>
<td>170.7</td>
<td></td>
</tr>
<tr>
<td>Percentage change</td>
<td>0.1%</td>
<td>-2.9%</td>
<td>0.8%</td>
<td>0.3%</td>
<td>-0.4%</td>
<td>-1.8%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Indicated (2017 Max chg 20%)</td>
<td>65.4</td>
<td>2.2</td>
<td>0.9</td>
<td>84.7</td>
<td>8.1</td>
<td>10.0</td>
<td>171.4</td>
<td></td>
</tr>
<tr>
<td>Percentage change</td>
<td>0.9%</td>
<td>-6.3%</td>
<td>1.2%</td>
<td>0.5%</td>
<td>-0.4%</td>
<td>-1.3%</td>
<td>0.4%</td>
<td></td>
</tr>
<tr>
<td>Indicated (2017 Max chg 15%)</td>
<td>66.2</td>
<td>2.2</td>
<td>0.9</td>
<td>84.8</td>
<td>8.1</td>
<td>10.1</td>
<td>172.2</td>
<td></td>
</tr>
<tr>
<td>Percentage change</td>
<td>2.0%</td>
<td>-8.2%</td>
<td>2.1%</td>
<td>0.7%</td>
<td>-0.4%</td>
<td>-0.6%</td>
<td>0.9%</td>
<td></td>
</tr>
</tbody>
</table>

### Notes
- Amounts in Billions
- Excluding Zero and Negative Size Companies
- “NOC,” standing for Not Otherwise Classified, means companies whose major line is one of the following: Special Liability, Fidelity/Surety, “Other,” International, Financial/Mortgage Guaranty, Warranty.
- Risk factors for “2014 Data” and “2017 Data” for catastrophe exposed LOBs, are reduced to reflect the fact that catastrophe risk is incorporated separately in the RBC Formula. We apply the multiplicative adjustment used by the NAIC. See footnote 4.
Part 2: Change in P&C RBC Charges by % Size in Change in RBC Value:
R4 Alone, R5 Alone, and Total ACL

% Change in Risk Charge  | 2020 to 2017 Uncapped | 2020 to 2017 Min 10% | 2020 to 2017 Max Chg 10% | 2020 to 2017 Max Chg 20% | 2020 to 2017 Max Chg 35%
--- | --- | --- | --- | --- | ---
P&C RBC - Distribution of Companies by Change of R4 Charges
% Changes in R4
Less Than -50% | 168 | 8 | 1 | 1 | 3
-50% to -25% | 19 | 71 | 1 | 10 | 56
-25% to -15% | 3 | 80 | 2 | 137 | 98
-15% to -5% | 135 | 167 | 308 | 180 | 169
-5% to 5% | 493 | 483 | 989 | 756 | 605
5% to 15% | 525 | 535 | 533 | 534 | 545
15% to 25% | 271 | 272 | 0 | 214 | 263
25% to 50% | 150 | 148 | 0 | 0 | 92
Over 50% | 73 | 73 | 3 | 5 | 6
Total | 1837 | 1837 | 1837 | 1837 | 1837
R5 - P&C RBC - Distribution of Companies by Change of R5 Charges
% Changes in R5
Less Than -50% | 19 | 17 | 2 | 3 | 11
-50% to -25% | 68 | 52 | 7 | 26 | 36
-25% to -15% | 54 | 43 | 21 | 40 | 53
-15% to -5% | 275 | 196 | 183 | 225 | 207
-5% to 5% | 1273 | 1377 | 1481 | 1405 | 1390
5% to 15% | 117 | 121 | 118 | 113 | 115
15% to 25% | 9 | 9 | 6 | 6 | 6
25% to 50% | 12 | 12 | 12 | 11 | 11
Over 50% | 10 | 10 | 7 | 8 | 8
Total | 1837 | 1837 | 1837 | 1837 | 1837
ACL - P&C RBC - Distribution of Companies by Change of ACL RBC
% Changes in ACL RBC
Less Than -50% | 26 | 0 | 0 | 0 | 0
-50% to -25% | 77 | 33 | 0 | 2 | 14
-25% to -15% | 55 | 49 | 1 | 35 | 48
-15% to -5% | 135 | 159 | 157 | 198 | 182
-5% to 5% | 1161 | 1199 | 1586 | 1419 | 1344
5% to 15% | 244 | 259 | 93 | 171 | 195
15% to 25% | 64 | 60 | 0 | 12 | 43
25% to 50% | 64 | 67 | 0 | 0 | 11
Over 50% | 11 | 11 | 0 | 0 | 0
Total | 1837 | 1837 | 1837 | 1837 | 1837

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NAIC Proceedings – Spring 2021
Attachment Four-C
Capital Adequacy (E) Task Force
3/23/21

Part 3: Change in P&C RBC Charges by Size of Company: R4 Alone, R5 Alone, and Total ACL
P&C RBC - Comparison of R4 by Company Size (L&LAE + NWP)
R4 \ Company Size
zero or less 0%-10%
10%-20% 20%-30% 30%-40% 40%-50% 50%-60% 60%-70% 70%-80% 80%-90% 90%-100% Total
2020 RBC Formula
156.0
19.3
74.3
189.0
355.5
712.7
1,119.9
2,430.2
4,566.6
12,271.0 101,666.8 123,561.5
Indicated (2014 Uncapped)
174.1
21.1
72.4
184.1
404.3
755.0
1,152.4
2,625.6
4,914.1
13,564.6 111,212.9 135,080.6
Percentage change
11.6%
9.1%
-2.6%
-2.5%
13.7%
5.9%
2.9%
8.0%
7.6%
10.5%
9.4%
9.3%
Indicated (2017 Uncapped)
180.5
19.7
68.0
171.9
377.1
726.1
1,129.3
2,520.3
4,850.3
13,322.5 109,632.5 132,998.2
Percentage change
15.7%
2.1%
-8.5%
-9.0%
6.1%
1.9%
0.8%
3.7%
6.2%
8.6%
7.8%
7.6%
Indicated (2017 Min 10%)
180.3
20.9
76.0
191.7
394.3
773.3
1,170.3
2,619.0
4,975.7
13,559.6 110,762.5 134,723.6
Percentage change
15.5%
8.5%
2.2%
1.5%
10.9%
8.5%
4.5%
7.8%
9.0%
10.5%
8.9%
9.0%
Indicated (2017 Max Chg 10%)
164.1
19.2
73.9
187.1
359.4
713.8
1,124.5
2,440.3
4,596.2
12,312.6 102,239.5 124,230.7
Percentage change
5.2%
-0.5%
-0.6%
-1.0%
1.1%
0.1%
0.4%
0.4%
0.6%
0.3%
0.6%
0.5%
Indicated (2017 Max Chg 20%)
171.8
19.4
73.1
186.2
363.8
720.4
1,134.2
2,467.9
4,660.9
12,517.1 104,022.3 126,337.1
Percentage change
10.1%
0.4%
-1.7%
-1.4%
2.3%
1.1%
1.3%
1.6%
2.1%
2.0%
2.3%
2.2%
Indicated (2017 Max Chg 35%)
176.9
19.8
73.8
187.4
371.1
733.3
1,145.6
2,505.6
4,736.3
12,778.6 105,677.0 128,405.5
Percentage change
13.4%
2.5%
-0.7%
-0.8%
4.4%
2.9%
2.3%
3.1%
3.7%
4.1%
3.9%
3.9%
P&C RBC - Comparison of R5 by Company Size (L&LAE + NWP)
R5 \ Company Size
zero or less 0%-10%
10%-20% 20%-30% 30%-40% 40%-50% 50%-60% 60%-70% 70%-80% 80%-90% 90%-100% Total
2020 RBC Formula
368.8
107.0
143.6
246.2
472.2
698.0
1,096.9
1,962.0
3,717.3
8,526.7
57,392.3
74,731.0
Indicated (2014 Uncapped)
367.6
106.5
137.3
235.8
456.7
686.5
1,049.7
1,893.3
3,607.5
8,293.0
56,476.0
73,309.9
Percentage change
-0.3%
-0.5%
-4.4%
-4.2%
-3.3%
-1.6%
-4.3%
-3.5%
-3.0%
-2.7%
-1.6%
-1.9%
Indicated (2017 Uncapped)
371.8
106.3
136.0
232.5
451.9
677.9
1,037.8
1,870.1
3,577.7
8,195.4
56,347.9
73,005.5
Percentage change
0.8%
-0.7%
-5.3%
-5.6%
-4.3%
-2.9%
-5.4%
-4.7%
-3.8%
-3.9%
-1.8%
-2.3%
Indicated (2017 Min 10%)
372.5
106.5
137.7
234.3
455.9
682.7
1,050.2
1,894.4
3,646.3
8,330.1
57,017.6
73,928.1
Percentage change
1.0%
-0.5%
-4.1%
-4.8%
-3.5%
-2.2%
-4.3%
-3.4%
-1.9%
-2.3%
-0.7%
-1.1%
Indicated (2017 Max Chg 10%)
372.7
107.0
142.1
243.6
466.8
693.0
1,080.2
1,940.2
3,678.3
8,414.1
57,165.8
74,303.9
Percentage change
1.1%
0.0%
-1.0%
-1.0%
-1.1%
-0.7%
-1.5%
-1.1%
-1.1%
-1.3%
-0.4%
-0.6%
Indicated (2017 Max Chg 20%)
372.5
106.8
140.5
240.9
462.8
688.9
1,067.3
1,922.0
3,647.0
8,340.8
56,778.5
73,768.1
Percentage change
1.0%
-0.2%
-2.1%
-2.2%
-2.0%
-1.3%
-2.7%
-2.0%
-1.9%
-2.2%
-1.1%
-1.3%
Indicated (2017 Max Chg 35%)
372.5
106.7
139.3
238.1
459.4
685.7
1,058.6
1,910.3
3,640.6
8,325.6
56,756.9
73,693.6
Percentage change
1.0%
-0.3%
-3.0%
-3.3%
-2.7%
-1.8%
-3.5%
-2.6%
-2.1%
-2.4%
-1.1%
-1.4%
P&C RBC - Comparison of ACL RBC by Company Size (L&LAE + NWP)
ACL RBC \ Company Size
zero or less 0%-10%
10%-20% 20%-30% 30%-40% 40%-50% 50%-60% 60%-70% 70%-80% 80%-90% 90%-100% Total
2020 RBC Formula
897.2
188.3
204.5
442.4
718.3
1,003.2
1,409.5
2,990.9
4,824.2
12,841.7 146,023.6 171,543.8
Indicated (2014 Uncapped)
901.3
189.0
202.6
439.4
731.6
1,020.6
1,407.4
3,032.7
4,951.8
13,367.4 150,037.4 176,281.3
Percentage change
0.5%
0.4%
-0.9%
-0.7%
1.9%
1.7%
-0.1%
1.4%
2.6%
4.1%
2.7%
2.8%
Indicated (2017 Uncapped)
903.5
188.5
200.8
434.8
720.1
1,008.8
1,396.5
3,006.1
4,922.8
13,243.7 149,267.4 175,292.9
Percentage change
0.7%
0.1%
-1.8%
-1.7%
0.3%
0.6%
-0.9%
0.5%
2.0%
3.1%
2.2%
2.2%
Indicated (2017 Min 10%)
903.7
188.7
202.9
439.2
725.2
1,022.2
1,410.4
3,039.4
4,973.1
13,336.1 149,629.1 175,870.2
Percentage change
0.7%
0.3%
-0.8%
-0.7%
1.0%
1.9%
0.1%
1.6%
3.1%
3.9%
2.5%
2.5%
Indicated (2017 Max Chg 10%)
900.6
188.3
203.5
440.6
716.4
1,000.7
1,403.0
2,985.0
4,816.0
12,821.3 146,144.3 171,619.7
Percentage change
0.4%
0.0%
-0.4%
-0.4%
-0.3%
-0.2%
-0.5%
-0.2%
-0.2%
-0.2%
0.1%
0.0%
Indicated (2017 Max Chg 20%)
902.0
188.3
202.8
439.3
716.5
1,001.4
1,401.5
2,988.2
4,830.4
12,881.4 146,718.4 172,270.1
Percentage change
0.5%
0.0%
-0.8%
-0.7%
-0.3%
-0.2%
-0.6%
-0.1%
0.1%
0.3%
0.5%
0.4%
Indicated (2017 Max Chg 35%)
903.1
188.3
202.6
438.7
718.1
1,005.4
1,402.5
2,998.0
4,860.4
12,986.9 147,413.2 173,117.2
Percentage change
0.6%
0.0%
-0.9%
-0.8%
0.0%
0.2%
-0.5%
0.2%
0.8%
1.1%
1.0%
0.9%

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Part 4: Type of Company Definition
For each company, the company is assigned to one of six categories—Personal Lines, Commercial Lines, Medical Professional Liability, Reinsurance, Workers’ Compensation, or Other—by determining the amount of premium plus reserves (net written premium, plus net loss and LAE unpaid) for each of the six categories (using the table shown below), and then determining the category with the highest amount of premium plus reserves.

<table>
<thead>
<tr>
<th>Schedule P Line</th>
<th>Category</th>
<th>Schedule P Line</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) H/F</td>
<td>Personal Lines</td>
<td>(12) APD</td>
<td>Personal Lines</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>Personal Lines</td>
<td>(10) Fidelity / Surety</td>
<td>Other</td>
</tr>
<tr>
<td>(3) CA</td>
<td>Commercial Lines</td>
<td>(13) Other</td>
<td>Other</td>
</tr>
<tr>
<td>(4) WC</td>
<td>Workers Compensation</td>
<td>(15) International</td>
<td>Other</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>Commercial Lines</td>
<td>(16) Reins. Prop. / Fin.</td>
<td>Reinsurance</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>Medical Malpractice</td>
<td>(17) Reins. Liab.</td>
<td>Reinsurance</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>Medical Malpractice</td>
<td>(18) Product Liab.</td>
<td>Commercial Lines</td>
</tr>
<tr>
<td>(8) SL</td>
<td>Other</td>
<td>(19) Financial / Mortgage</td>
<td>Other</td>
</tr>
<tr>
<td>(9) OL</td>
<td>Commercial Lines</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Part 5: LOB Share With Each Type of Company
The table below shows the proportion of NWP+Loss and LAE reserve by LOB within each of the type of company categories.

<table>
<thead>
<tr>
<th>LOB (Category)</th>
<th>Commercial</th>
<th>Med Mal</th>
<th>NOC</th>
<th>Personal</th>
<th>Reinsurer</th>
<th>Workers Comp</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>H/F</td>
<td>6%</td>
<td>0%</td>
<td>0%</td>
<td>17%</td>
<td>2%</td>
<td>4%</td>
<td>10%</td>
</tr>
<tr>
<td>PPA</td>
<td>6%</td>
<td>0%</td>
<td>0%</td>
<td>45%</td>
<td>2%</td>
<td>4%</td>
<td>22%</td>
</tr>
<tr>
<td>CA</td>
<td>8%</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>2%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>WC</td>
<td>16%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
<td>2%</td>
<td>73%</td>
<td>15%</td>
</tr>
<tr>
<td>CMP</td>
<td>10%</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>1%</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>MPL Occ</td>
<td>0%</td>
<td>24%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>MPL CM</td>
<td>1%</td>
<td>72%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>SL</td>
<td>2%</td>
<td>0%</td>
<td>20%</td>
<td>0%</td>
<td>2%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>OL</td>
<td>30%</td>
<td>2%</td>
<td>22%</td>
<td>3%</td>
<td>6%</td>
<td>6%</td>
<td>16%</td>
</tr>
<tr>
<td>FID/SUR</td>
<td>1%</td>
<td>0%</td>
<td>38%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>SP</td>
<td>9%</td>
<td>0%</td>
<td>2%</td>
<td>2%</td>
<td>6%</td>
<td>1%</td>
<td>5%</td>
</tr>
<tr>
<td>APD</td>
<td>4%</td>
<td>0%</td>
<td>18%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
<td>9%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
<td>0%</td>
<td>13%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Fin/Mortgage</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>INTL</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Rein (Prop and LIAI)</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>21%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Rein (LIAI)</td>
<td>3%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
<td>49%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>PL</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>WAR</td>
<td>0%</td>
<td>0%</td>
<td>4%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Total %</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Total $</td>
<td>612,343,230</td>
<td>21,289,449</td>
<td>7,851,892</td>
<td>524,169,525</td>
<td>14,841,788</td>
<td>119,683,083</td>
<td>1,300,178,967</td>
</tr>
</tbody>
</table>

We see that the main LOBs within the category NOC are Fidelity/Surety, Other Liability and Special Liability, and we see that the Medical Professional Type of Company is predominantly Medical Professional Liability Claims Made.
18. APPENDIX 14—REFERENCES


Premium Risk Charges—Improvements to Current Calibration Method (Report 6)  
http://www.casact.org/pubs/forum/13fforum/01-Report-6-RBC.pdf  
Reserve Risk Charges—Improvements to Current Calibration Method (Report 7)  


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19. APPENDIX 15—May 2019 Letter to NAIC
May 8, 2019

Tom Botsko, Chair
Property and Casualty Risk-Based Capital Working Group
National Association of Insurance Commissioners
(via email to Eva Yeung)

Dear Tom:

The American Academy of Actuaries1 Property and Casualty Risk-Based Capital (RBC) Committee plans to support the National Association of Insurance Commissioners’ efforts to update the calibration of factors used to calculate underwriting (UW) risk. This letter describes our plans. We appreciate this opportunity to describe those plans and solicit input from the NAIC Property and Casualty RBC Working Group.

1. Overview

We plan to analyze the following:

- Investment Income Adjustment (IIA)—RBC Line 8 on page PR017 (R4 Reserve risk) and Line 7 on page PR018 (R5 Premium risk), by Line of Business (LOB);

- Loss Concentration Factor (LCF) and Premium Concentration Factor (PCF)—RBC Line 14 on PR017 and PR018 respectively, which are used to calculate diversification credit in the RBC Formula; and

- LOB UW risk factors—RBC Line 4 on PR017 and PR018. We will use the results of this review as a starting point for the IIA and LCF/PCF analysis. This review will include the use of data not available to this Academy committee at the time the 2016 Academy Report2 was provided.

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1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policy makers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

The remainder of this letter provides more details regarding our proposed analyses.

2. IIA Analysis (Line 8/7)

The IIA reduces the amount of UW risk charge to recognize that future investment income will be available to offset the cost of adverse UW (premium risk) or reserve development (reserve risk).

Evaluation approach
The IIAs are based on a 5% per annum interest rate assumption, which is not consistent with recent experience.

We will consider two ways to update the IIAs. First, the Line 4 risk factor and the IIA on Lines 8/7 are currently calibrated as independent parameters. We use the term Nominal Value Approach (NVA) to describe an approach that does not consider possible interactions between interest rates underlying the IIA and loss experience underlying the Line 4 risk factors.

Implementing NVA requires changing the IIAs to reflect changing interest rates over time. We will consider how that might be done in a manner that provides reasonable stability but remains responsive to current conditions.

Second, we note that there are reasons to expect that loss ratios (LRs) and reserve runoff ratios (RRRs) are higher when interest rates are higher.3 An alternative to NVA, which considers a possible interaction between UW risk and interest rates, is to calibrate UW risk factors (Line 4) using data discounted to present value based on historical interest rates. Risk factors and IIAs can be developed from that analysis. We refer to that alternative as the Present Value Approach (PVA).

With PVA, we would establish the combined effect of the underwriting risk factors (Line 4) and the IIA (Line 8/7). We would produce a single indicated risk factor that reflects both UW risk, Line 4, and IIA, Lines 8/7. If desired, for consistency with the current format of the RBC Formula, that combined risk factor can be split into its two components. However, future changes in interest rates will not necessarily require changes in the IIA values.

We plan to prepare indicated risk factors for IIAs based on both NVA and PVA.

Interaction with UW risk safety level
Consistent with prior calibrations, UW risk factor Line 4 calibrations prepared for the NAIC in the 2016 Report are based on an 87.5th percentile safety level. We understand

the 87.5th percentile is used because it appeared to be consistent with the UW risk safety level selected when the RBC Formula was first calibrated in the early 1990s.

The 5% interest rate was also selected in the initial RBC calibration in the early 1990s. At that time actual interest rates were higher than 5%. Therefore, the initial IIA calibration can be viewed as including an implicit interest rate safety margin—that being the difference between actual interest rates at the time and the 5% interest rate selected.

In the IIA analysis, we will use interest rates with and without the kind of implicit safety margin that was part of the RBC calibration in the early 1990s. In using interest rates with no implicit safety margin, we will consider the extent to which the UW risk safety level should be increased to a value above 87.5%, to reflect the combination of the current 87.5th percentile on UW risk and any implicit interest rate safety margin. We will provide the NAIC with alternative treatments on this issue.

3. LCF/PCF Analysis (Line 14)

The LCF/PCF uses the ratio of the reserve/premium amount for the company’s largest RBC LOB to the company’s all-lines total reserve/premium amount. This ratio is used to measure the spread of business by LOB, commonly called diversification. We refer to that ratio as the Company Line of Business Maximum% (CoMaxLine%).

The LCF/PCF equals CoMaxLine% times 0.3 plus 0.7. This produces a discount for diversification, up to a maximum somewhat less than 30%.

Evaluation of 30% Maximum Diversification Credit

The proposed work will review the extent to which the 30% maximum should be revised based on experience.

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4 The maximum credit would be 30% if the number of LOBs were infinite. If premium/reserves were divided equally among the 19 LOBs, CoMaxLine% is 1/19, 5.26%, and the maximum credit is 28.4%.
Evaluation of other approaches

There are alternatives to the CoMaxLine% Approach in the RBC formula. One alternative approach is to use the largest LOB risk amount, rather than the largest reserve/premium amount. We refer to this as the CoMaxLine%-Risk approach. 5,6

Another alternative approach to evaluating diversification could be based on the Herfendahl-Hirschman Index (HHI). HHI is widely used by economists to measure concentration. The HHI index considers the relative proportions of all LOBs (largest, second-largest, third-largest, etc.) 7, whereas the CoMaxLine% approach only considers the relative proportion of the largest LOB.

We will evaluate these alternatives.

4. Update to UW factors

The UW factors presented in the 2016 Report are based on data for Annual Statement years 1997–2014. For this work, the NAIC has provided data for Annual Statement years 1984–2017. We plan to update UW factors to include the additional new years (2015–2017), and we will potentially use data from Annual Statement years prior to 1997 for specific LOBs.

Our indicated risk factors will include the effect of catastrophe events, net of reinsurance. We expect that the NAIC will continue to apply its current catastrophe adjustment

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5 As an example of the difference between the risk maximum and the premium/reserve (volume) maximum, consider a hypothetical company that had $1 million of private passenger liability premium and $1 million of occurrence medical malpractice premium.

   The private passenger automobile risk premium charge is about 15% and malpractice occurrence premium risk charge is about 60%, producing $150,000 of automobile premium risk, $600,000 of medical malpractice premium risk, and $750,000 in total premium risk (before diversification).

   Using the CoMaxLine% approach in the RBC Formula, the CoMaxLine% is 0.50, and the credit for spread of business is 15%, half of the 30% maximum credit.

   Based on risk, the maximum risk is the $600,000 for occurrence medical malpractice and the CoMaxLine%-Risk is 0.80 (600,000/750,000). The CoMaxLine%-Risk is much higher than CoMaxLine% because from the risk perspective the company is much less diversified. Measured this way, the credit for spread of business is reduced to 6%.

6 Using risk by LOB suggests the use of expenses by LOB. Expenses by LOB for the current year are in the Insurance Expense Exhibit, which is not filed until a month after the Annual Statement is filed. We will test options that use data that is available when the Annual Statement is filed, e.g., current year total expenses allocated by LOB based on prior year expenses by LOB, prior year expense by LOB with no adjustment to the current year, and current year company-wide expenses that does not vary by LOB.

7 HHI equals the sum of the squares of the relative proportions of each LOB compared to the total.

   For example, if there is only one LOB, HHI is 1.0, as is the case for the CoMaxLine%. With two lines split 50% and 50% HHI and the CoMaxLine% are still the same, both 0.5.

   With two lines split 25% and 75% HHI is 0.25\(^2\) plus 0.75\(^2\) or 0.625 compared to the CoMaxLine% of 0.750, i.e., HHI shows more diversification. With three lines split 50%, 25% and 25% HHI is 0.50\(^2\) plus 0.25\(^2\) plus 0.25\(^2\) or 0.375, more diversification than the CoMaxLine% of 0.5.

   The HHI is sometimes applied to only the n-th largest segments, e.g., the degree of diversification among the top five or 10 LOBs.

8 Annual Statements 1989 and subsequent for reserve risk data.
process to any updated UW risk factors it may choose to implement based on the results of our analysis. 9

5. Timeline

NAIC staff have provided us with much of the necessary data. We greatly appreciate that assistance, without which this project would not be possible.

We are currently reviewing the data and organizing it for our analyses.

We will provide a timeline and milestones at future meetings and calls.

6. Directional Impacts of These Analyses on RBC Formula Values

While we currently have no results, based on the nature of the changes, we expect that:

- The IIA revision will indicate an increase in amount of UW risk charges for all companies; and
- The LCF/PCF analysis will generally indicate a decrease in amount of UW risk charges for diversified companies.

We expect to provide possible transition rules for implementation, consistent with past practice and/or if such rules appear warranted by features in the data.

Also, as we have in the past, we will ask NAIC to do an impact review of indicated changes.

* * * *

We appreciate this opportunity to assist the NAIC.

Regards,

Lauren Cavanaugh
Chairperson
Academy Property & Casualty
Risk-Based Capital Committee

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9 The Academy P&C RBC Committee would be happy to discuss how we might assist the NAIC in calibration of the risk factors on a net-of-catastrophe basis, but we believe that should be a separate project, after we complete the projects we describe in this letter.
<table>
<thead>
<tr>
<th>Line</th>
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<th>RRC%</th>
<th>% Change</th>
</tr>
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<td>25.3%</td>
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<td>(2) PPA</td>
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## Comparison of Risk Factors

### 2020 RBC Formula versus 2017 Indicated

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<th>PRC%</th>
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<th>% Change 2020 RBC Formula</th>
<th>% Change 2020 RBC Formula</th>
<th>Indicated (2017 Data)</th>
<th>% Change 2020 RBC Formula</th>
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<tr>
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<td>34.3%</td>
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<td>CMP</td>
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<td>Spec. Prop.</td>
<td>19.1%</td>
<td>18.9%</td>
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<td>Reins. Prop. / Fin.</td>
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</tr>
</tbody>
</table>

### Average Risk Factor - all Lines

- Average Risk Factor - all Lines: 23.4% 23.8% 1.6% 36.2% 37.6% 12.9%
- Average Risk Factor - 10-Yr Lines: 26.9% 26.7% -0.5% 39.4% 40.1% 2.3%
- Average Risk Factor - 2-Yr Lines: 14.6% 16.3% 11.6% 22.6% 21.8% 2.3%
TO: Tom Bostko (OH), Chair, Capital Adequacy (E) Task Force  
FROM: Philip Barlow (DC), Chair, Life Risk-Based Capital (E) Working Group  
DATE: January 21, 2021  
RE: Recommendation Regarding Risk-Based Capital Charge for Guaranty Association Assessment Risk

The Life Risk-Based Capital (E) Working Group received a request from the Capital Adequacy (E) Task Force to review the referral letter regarding adopted amendments to the *Life and Health Insurance Guaranty Association Model Act*, Model #520. The referral outlined significant amendments to Model #520, including: 1) broadening the assessment base for long-term care insurance (LTCI) insolvencies to include both life and health insurers and splitting the assessment 50%/50% between the life and health insurers; 2) clarifying the guaranty associations’ coverage of LTCI; and 3) including health maintenance organizations (HMOs) as members of the guaranty association, similar to other health insurers. The referral letter requested that the Task Force consider if changes were warranted to the life RBC formula in light of the changes made to Model #520. The reason for this item being referred to the Working Group was concern with the fact that the C-4a risk component is based on the amount of guaranty fund assessments. The risk charge is based on the maximum amount of assessments in any one year for a life company, and that is not affected by the changes to Model #520.

Based on the current instructions and reporting, the Working Group does not believe that modifications to the life RBC formula are required for the change to Model #520.

The recommendation above does not preclude the Working Group from potential changes to long-term care or the business risk component charge in the future.

If you have any questions regarding this memorandum, please contact me at philip.barlow@dc.gov or Dave Fleming (NAIC) at dfleming@naic.org.
Capital Adequacy (E) Task Force
RBC Proposal Form

DATE: 10-15-20
FOR NAIC USE ONLY

CONTACT PERSON: Jane Barr
TELEPHONE: ____________________________
EMAIL ADDRESS: ____________________________
ON BEHALF OF: Capital Adequacy Task Force
NAME: Tom Botsko
TITLE: ____________________________
AFFILIATION: ____________________________
ADDRESS: ____________________________

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED
[ X ] Health RBC Blanks  [ X ] Property/Casualty RBC Blanks  [ ] Life and Fraternal RBC Instructions
[ X ] Health RBC Instructions  [ X ] Property/Casualty RBC Instructions  [ ] Life and Fraternal RBC Blanks
[ ] OTHER ____________________________

DESCRIPTION OF CHANGE(S)
Modified the structure for the bonds to pull directly from Schedule D, Schedule DA and Schedule E footnotes for the 20 RBC bond designations. Exempt bonds (Line 1) is pulled direct from Schedule D, Part 1, Col. 11, Line 0599999; Schedule DA, Part 1, Col. 7, Line 0599999; and Schedule E, Part 2, Col. 7, Line 0599999 + 8599999.

Hybrid securities will be incorporated into the bonds.

P/C blanks and instruction pages impacted: PR006, PR007, PR011, PR015, PR030, PR031 and PR032.

Health blanks and instruction pages impacted: XR006, XR007.1, XR007.2, XR009, XR011, XR023 and XR024.

REASON OR JUSTIFICATION FOR CHANGE **
The structure of the bonds reported in the health and P/C RBC formulas will be modified to pull from the footnotes of Schedule D, Part 1; Schedule DA, Part 1; and Schedule E, Part 2 for greater consistency and transparency in the RBC reporting. Hybrid securities reported as in Schedule D, Part 1; Schedule DA, Part 1; and Schedule E, Part 2 will be reported as a bond in on the Bonds pages and removed as a separate section in the health and P/C RBC blanks (XR009 and PR007).

Once the factors have been finalized, they will be incorporated into the proposal.

Additional Staff Comments:
10/27/20 jdb Exposed for a 45-day comment period.
01/12/21 cgb Editorial change made to page XR008 to strike-through the “Schedule E, Part 2” in line description and “in part” reference in the Annual Statement Source column for Line (30).
OFF-BALANCE SHEET SECURITY LENDING COLLATERAL AND SCHEDULE DL, PART 1 ASSETS
XR006

Security lending programs are required to maintain collateral. Some entities post the collateral supporting security lending programs on their financial statements and incur the related risk charges on those assets. Other entities have collateral that is not recorded on their financial statements. While not recorded on the financial statements of the company, such collateral has risks that are not otherwise captured in the RBC formula.

The collateral in these accounts is maintained by a third party (typically a bank or other agent). The collateral agent maintains on behalf of the company detail asset listings of the collateral assets, and this data is the source for preparation of this schedule. The company should maintain such asset listings, at a minimum CUSIP, market value, book/adjusted carrying value, and maturity date.

The asset risk charges are derived from existing RBC factors for bonds, preferred and common stocks, other invested assets, and invested assets not otherwise classified (aggregate write-ins).

Specific Instructions for Application of the Formula


Off-balance sheet collateral included in General Interrogatories Part 1, Lines 24.05 and 24.06 of the annual statement should agree with Line (40), Column (1).

Lines (1) through (27) – Bonds – Bond factors described on page XR007 – Fixed Income Assets.

Line (28) through (34) – Preferred Stock – Preferred stock factors described on page XR010 – Equity Assets.

Line (35) – Common Stock – Common stock factors described on page XR010 – Equity Assets.


Line (37) – Other Invested Assets – Other invested assets factor described on page XR008 – Fixed Income Assets.

Line (38) – Mortgage Loans on Real Estate – Mortgage Loans on Real Estate factors described on page XR008 – Fixed Income Assets.

Line (39) – Cash, Cash Equivalents and Short-Term Investments – Cash, Cash Equivalents and Short-Term Investments factors described on page XR008 – Fixed Income Assets.

FIXED INCOME ASSETS
XR007 AND XR008

The RBC requirement for fixed income assets is largely driven by the default risk on those assets. There are two major subcategories: Bonds and Miscellaneous. Bonds include item that meet the definition of a bond, regardless if the bond is long-term (reported on Schedule D-1), short-term (reported on schedule DA) or a cash equivalent...
Collateral Loans reported on Line (40) receive a factor of 5 percent, consistent with other risk-based capital formulas studied by the Working Group.

Bonds (XR007)

The bond factors for investment grade bonds (NAIC Designation Category 1.A-2.C) are based on cash flow modeling. Each bond of a portfolio was annually tested for default (based on a “roll of the dice”) where the default probability varies by NAIC Designation Category and that year’s economic environment. The default probabilities were based on historical data intended to reflect a complete business cycle of favorable and unfavorable credit environments. The risk of default was measured over a___-year time horizon, based on the duration of assets or liabilities held for health companies.

The factors for NAIC Designation Category 3.A to 6 recognize that these non-investment grade bonds are reported at the lower of amortized cost or fair value. These bond risk factors are based on the market value fluctuation for each of the NAIC designation category compared to the market value fluctuation of stocks during the 2008-2009 financial crisis.

While the life and property/casualty formulas have a separate calculation for the bond size factor (based on the number of issuers in the RBC filer's portfolio), the health formula does not include a separate calculation, instead a bond size component was incorporated into the bond factors. A representative portfolio of 382 issuers was used in calculating the bond risk factors.

There is no RBC requirement for bonds guaranteed by the full faith and credit of the United States, Other U.S. Government Obligations, and securities on the NAIC U.S. Government Money Market Fund List because it is assumed that there is no default risk associated with U.S. Government issued securities.

The book/adjusted carrying value of all bonds should be reported in Columns (1), (2) or (3). The bonds are split into twenty-one different risk classifications. These risk classifications are based on the NAIC Designation Category as defined and permitted in the Purposes and Procedures Manual of the NAIC Investment Analysis Office. The subtotal of Columns (1), (2) and (3) will be calculated in Column (4). The RBC requirement will be automatically calculated in Column (5).

Miscellaneous Fixed Income Assets (XR008)

The factor for cash is 0.3 percent. It is recognized that there is a small risk related to possible insolvency of the bank where cash deposits are held. This factor was based on the original unaffiliated NAIC 01 bond risk factor prior to the increased granularity of the NAIC Designation Categories in 2021, and reflects the short-term nature of this risk. The required risk-based capital for cash will not be less than zero, even if the company’s cash position is negative.

The Short-Term Investments to be included in this section are those short-term investments not reflected elsewhere in the formula. The 0.3 percent factor is equal to the factor for cash. The amount reported in Line (35) reflects the total from Schedule DA: Short-Term Investments (Line 33), less the short-term bonds (Line 34). (The short-term bonds reported in Line (34) should equal Schedule DA, Part 1, Column 7, Line ___.)

Mortgage loans (reported on Schedule B) and Derivatives (reported on Schedule DB) receive a factor of 5 percent, consistent with other risk-based capital formulas studied by the Working Group.

The following investment types are captured on Schedule BA: Other Long-Term Invested Assets. Specific factors have been established for certain Schedule BA assets based on the nature of the investment. Those Schedule BA assets not specifically identified below receive a 20 percent factor (Line (43)).

- Collateral Loans reported on Line (40) receive a factor of 5 percent, consistent with other risk-based capital formulas studied by the Working Group.
Working Capital Finance Investments: The book adjusted carrying value of NAIC 01 and 02 Working Capital Finance Investments, Lines (41) and (42), should equal the Notes to Financial Statement, Lines 5M(01a) and 5M(01b), Column 3 of the annual statement.

Low income housing tax credit investments are reported in Column (1) in accordance with SSAP No. 93—Low Income Housing Tax Credit Property Investments.

- Federal Guaranteed Low-Income Housing Tax Credit (LIHTC) investments are to be included in Line (44). There must be an all-inclusive guarantee from an ARO-rated entity that guarantees the yield on the investment.

- Federal Non-Guaranteed LIHTC investments with the following risk mitigation factors are to be included in Line (45):
  - A level of leverage below 50 percent. For a LIHTC Fund, the level of leverage is measured at the fund level.
  - A tax credit guarantee agreement from general partner or managing member. This agreement requires the general partner or managing member to reimburse investors for any shortfalls in tax credits due to errors of compliance, for the life of the partnership. For an LIHTC fund, a tax credit guarantee is required from the developers of the lower-tier LIHTC properties to the upper-tier partnership.

- State Guaranteed LIHTC investments that at a minimum meet the federal requirements for guaranteed LIHTC investments are to be included in Line (46).

- State Non-Guaranteed LIHTC investments that at a minimum meet the federal requirements for non-guaranteed LIHTC investments are to be included on Line (47).

- All Other LIHTC investments, state and federal LIHTC investments that do not meet the requirements of Lines (44) through (47) would be reported on Line (48).

**EQUITY ASSETS**

**XR010**

Unaffiliated Preferred Stocks

Experience data to develop preferred stock factors is not readily available; however, it is believed that preferred stocks are somewhat more likely to default than bonds. The loss on default would be somewhat higher than that experienced on bonds; however, formula factors are equal to bond factors.

The RBC requirements for unaffiliated preferred stocks are based on the NAIC designation. Column (1) amounts are from Schedule D, Part 2, Section 1 not including affiliated preferred stock. The preferred stocks must be broken out by asset designation (NAIC 01 through NAIC 06) and these individual groups are to be entered in the appropriate lines. The total amount of unaffiliated preferred stock reported should equal annual statement Page 2, Column 3, Line 2.1, less any affiliated preferred stock in Schedule D Summary by Country, Column 1, Line 18.

Unaffiliated Common Stock

Federal Home Loan Bank Stock has characteristics more like a fixed income instrument rather than common stock. A 2.3 percent factor was chosen. The factor for other unaffiliated common stock is based on studies which indicate that a 10 percent to 12 percent factor is needed to provide capital to cover approximately 95 percent of the greatest losses in common stock over a one-year future period. The higher factor of 15 percent contained in the formula reflects the increased risk when testing a period in excess of one year. This factor assumes capital losses are unrealized and not subject to favorable tax treatment at the time of loss in market value.
The purpose of the asset concentration calculation is to reflect the additional risk of high concentrations of certain types of assets in single exposures, termed “issuers.” An issuer is a single entity, such as IBM or the Ford Motor Company. When the reporting entity has a large portion of its asset portfolio concentrated in only a few issuers, there is a heightened risk of insolvency if one of those issuers should default. An issuer may be represented in the reporting entity’s investment portfolio by a single security designation, such as a large block of NAIC Designation Category 2.A bonds, or a combination of various securities, such as common stocks, preferred stocks, and bonds. The additional RBC for asset concentration is applied to the ten largest issuers.

Concentrated investments in certain types of assets are not expected to represent an additional risk over and above the general risk of the asset itself. Therefore, prior to determining the ten largest issuers, you should exclude those assets that are exempt from the asset concentration factor. Asset types that are excluded from the calculation include: NAIC 06 bonds and unaffiliated preferred stock; affiliated common stock; affiliated preferred stock; property and equipment; U.S. government full faith and credit, other U.S. government obligations, and NAIC U.S. government money market fund list securities; NAIC 01 bonds and unaffiliated preferred stock; any other asset categories with risk-based capital factors less than 1 percent, and investment companies (mutual funds) and common trust funds that are diversified within the meaning of the federal Investment Company Act of 1940 [Section 5(b) (1)]. The pro rata share of individual securities within an investment company (mutual fund) or common trust fund are to be included in the determination of concentrated investments, subject to the exclusions identified.

With respect to investment companies (mutual funds) and common trust funds, the reporting entity is responsible for maintaining the appropriate documentation as evidence that such is diversified within the meaning of the federal Investment Company Act and providing this information upon request of the Commissioner, Director or Superintendent of the Department of Insurance. The reporting entity is also responsible for maintaining a listing of the individual securities and corresponding book/adjusted carrying values making up its investment companies (mutual funds) and common trust funds portfolio, in order to determine whether a concentration charge is necessary. This information should be provided to the Commissioner, Director or Superintendent upon request.

The assets that ARE INCLUDED in the calculation when determining the 10 largest issuers are as follows:

- NAIC Designation Category 2.A – 2.C Bonds
- NAIC Designation Category 5.A – 5.C Bonds
- Collateral Loans
- Mortgage Loans
- NAIC 02 Unaffiliated Preferred Stock
- NAIC 03 Unaffiliated Preferred Stock
- NAIC 04 Unaffiliated Preferred Stock
- NAIC 05 Unaffiliated Preferred Stock
- Other Long-Term Assets
- NAIC 02 Working Capital Finance Investments
- Federal Guaranteed Low Income Housing Tax Credits
- Federal Non-Guaranteed Low Income Housing Tax Credits
- State Guaranteed Low Income Housing Tax Credits
- State Non-Guaranteed Low Income Housing Tax Credits
All Other Low Income Housing Tax Credits
Unaffiliated Common Stock

The concentration factor basically doubles the risk-based capital factor (up to a maximum of 30 percent) for assets held in the 10 largest issuers. Since the risk-based capital of the assets included in the concentration factor has already been counted once in the basic formula, this factor itself only serves to add an additional risk-based capital requirement on these assets.

The name of each of the largest 10 issuers is entered at the top of the table and the appropriate statement amounts are entered in Column (2), Lines (1) through (26). Aggregate all similar asset types before entering the amount in Column (2). To determine the 10 largest issuers, first pool all of the assets subject to the concentration factor. From this pool, aggregate the various securities by issuer. The aggregate book/adjusted carrying values for the assets are computed, and the 10 largest are subject to the concentration factor. For example, an organization might own $6,000,000 in NAIC Designation Category 2.A bonds of IBM, plus $4,000,000 in NAIC Designation Category 2.C plus $5,000,000 of common stock. The total investment in that issuer is $15,000,000. If that is the largest issuer, then the identifier (“IBM Corporation”) would be entered in the space allowed for the first Issuer Name, and the $6,000,000 would be entered under the book/adjusted carrying value column for Line (1) (NAIC Designation Category 2.A Bonds) $4,000,000 would be entered on Line (3) (NAIC Designation Category 2.C Bonds) and the $5,000,000 would be entered on Line (22) (Unaffiliated Common Stock).

Replicated assets other than synthetically created indices should be included in the asset concentration calculation in the same manner as other assets.
## Off-Balance Sheet Security Lending Collateral and Schedule DL, Part 1 Assets

### Fixed Income Assets

<table>
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<tr>
<th>Asset Category</th>
<th>Annual Statement Source</th>
<th>Off-Balance Sheet Collateral</th>
<th>Schedule DL, Part 1</th>
<th>Book/Adjusted Carrying Value</th>
<th>Book/Adjusted Carrying Value</th>
<th>Subtotal</th>
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### Equity Assets

| Asset Category | Annual Statement Source | Off-Balance Sheet Collateral | Schedule DL, Part 1 | Book/Adjusted Carrying Value | Book/Adjusted Carrying Value | Subtotal | Factor | RBC |
|----------------|------------------------|------------------------------|---------------------|                             |                             |          |        |     |
| Preferred Stock - Unaffiliated | Company Records | 0 | 0 | 0 | 0 | 0 | 0.003 | 0 |
| (28) NAIC 01 Unaffiliated Preferred Stock | Company Records | 0 | 0 | 0 | 0 | 0 | 0.003 | 0 |
| (29) NAIC 02 Unaffiliated Preferred Stock | Company Records | 0 | 0 | 0 | 0 | 0 | 0.003 | 0 |
| (30) NAIC 03 Unaffiliated Preferred Stock | Company Records | 0 | 0 | 0 | 0 | 0 | 0.003 | 0 |
| (31) NAIC 04 Unaffiliated Preferred Stock | Company Records | 0 | 0 | 0 | 0 | 0 | 0.003 | 0 |
| (32) NAIC 05 Unaffiliated Preferred Stock | Company Records | 0 | 0 | 0 | 0 | 0 | 0.003 | 0 |
| (33) NAIC 06 Unaffiliated Preferred Stock | Company Records | 0 | 0 | 0 | 0 | 0 | 0.003 | 0 |
| (34) Total Unaffiliated Preferred Stock | Sum of Lines (28) through (33) | 0 | 0 | 0 | 0 | 0 | 0.003 | 0 |
| (35) Unaffiliated Common Stock | Company Records | 0 | 0 | 0 | 0 | 0 | 1.500 | 0 |
| (36) Real Estate and Property & Equipment Assets | Company Records | 0 | 0 | 0 | 0 | 0 | 1.500 | 0 |
| (37) Other Invested Assets | Company Records | 0 | 0 | 0 | 0 | 0 | 0.200 | 0 |
| (38) Mortgage Loans on Real Estate | Company Records | 0 | 0 | 0 | 0 | 0 | 0.050 | 0 |
| (39) Colo, Cash Equivalents and Short-Term Investments (Not reported on Bonds above) | Company Records | 0 | 0 | 0 | 0 | 0 | 0.003 | 0 |
| (40) Total | Lines (27) + (34) + (36) + (37) + (38) + (39) | 0 | 0 | 0 | 0 | 0 | 0.003 | 0 |

Denotes items that must be manually entered on the filing software.
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<td>Total Bonds RBC</td>
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Denotes items that must be vendor linked.

Page numbers have been updated based on proposal 2020-0341 that will be considered by the HRSCWG on the Oct. 29, 2020 call.
### FIXED INCOME ASSETS (cont.)
#### MISCELLANEOUS FIXED INCOME ASSETS

| (28) Cash |
| (29) Cash Equivalents |
| (30) Less: Cash Equivalents, Total Bonds as Identified by SVO |
| (31) Less: Exempt Money Market Mutual Funds |
| (32) Net Cash Equivalents |
| (33) Short-Term Investments |
| (34) Short-Term Bonds |
| (35) Total Other Short-Term Investments |
| (36) Mortgage Loans - First Liens |
| (37) Mortgage Loans - Other Than First Liens |
| (38) Receivable for Securities |
| (39) Aggregate Write-Ins for Invested Assets |
| (40) Collateral Loans |
| (41) NAIC 01 Working Capital Finance Investments |
| (42) NAIC 02 Working Capital Finance Investments |
| (43) Other Long-Term Invested Assets Excluding Collateral Loans and Working Capital Finance Investments |
| (44) Federal Guaranteed Low Income Housing Tax Credits |
| (45) Federal Non-Guaranteed Low Income Housing Tax Credits |
| (46) State Guaranteed Low Income Housing Tax Credits |
| (47) State Non-Guaranteed Low Income Housing Tax Credits |
| (48) All Other Low Income Housing Tax Credits |
| (49) Total Other Long-Term Invested Assets (Page 2, Col 3, Line 8) |
| (50) Derivatives |
| (51) Total Fixed Income Assets RBC |

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Denotes items that must be manually entered on filing software.

* These bonds appear in page XR007 Schedule D Part 1A Section 1 and are already recognized in the Bond portion of the formula.

Page numbers have been updated based on proposal 2020-07-H that will be considered by the HRBCWG on the Oct. 29, 2020 call.
# EQUITY ASSETS

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(Should equal Page 2, Column 3, Line 2.1 less Sch D Sum, Column 1, Line 18)

## HYBRID SECURITIES - UNAFFILIATED

| (8) | NAIC 01 Hybrid Securities | Schedule D, Part 1A, Section 1, Column 7, Line 7.1 | Factor | 0.003 |
| (9) | NAIC 02 Hybrid Securities | Schedule D, Part 1A, Section 1, Column 7, Line 7.2 | | 0.010 |
| (10) | NAIC 03 Hybrid Securities | Schedule D, Part 1A, Section 1, Column 7, Line 7.3 | | 0.020 |
| (11) | NAIC 04 Hybrid Securities | Schedule D, Part 1A, Section 1, Column 7, Line 7.4 | | 0.045 |
| (12) | NAIC 05 Hybrid Securities | Schedule D, Part 1A, Section 1, Column 7, Line 7.5 | | 0.100 |
| (13) | NAIC 06 Hybrid Securities | Schedule D, Part 1A, Section 1, Column 7, Line 7.6 | | 0.300 |
| (14) | Subtotal - Hybrid Securities | Sum of Lines (8) through (13) | | |
| (15) | Total Unaffiliated Preferred Stock and Hybrids | Lines (7) + (14) | | |

## COMMON STOCK - UNAFFILIATED

| (8) | Federal Home Loan Bank Stock | Company Records | Factor | 0.023 |
| (9) | Total Common Stock | Schedule D, Summary, Column 1, Line 25 | | |
| (10) | Affiliated Common Stock | Schedule D, Summary, Column 1, Line 24 | | 0.150 |
| (11) | Other Unaffiliated Common Stock | Lines (9) - (8) - (10) | | |
| (12) | Total Unaffiliated Common Stock | Lines (8) + (11) | | |

Denotes items that must be manually entered on filing software.

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Page numbers have been updated based on proposal 2020-07-H that will be considered by the HRBCWG on the Oct. 29, 2020 call.
# Asset Concentration

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<tr>
<td>01 (2)</td>
<td>NAIC Designation Category 2.B Bonds</td>
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<td>$0</td>
<td></td>
</tr>
<tr>
<td>01 (3)</td>
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<tr>
<td>01 (4)</td>
<td>NAIC Designation Category 3.A Bonds</td>
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<tr>
<td>01 (5)</td>
<td>NAIC Designation Category 3.B Bonds</td>
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<tr>
<td>01 (6)</td>
<td>NAIC Designation Category 3.C Bonds</td>
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<td>NAIC Designation Category 4.A Bonds</td>
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<td>01 (8)</td>
<td>NAIC Designation Category 4.B Bonds</td>
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<tr>
<td>01 (12)</td>
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<tr>
<td>01 (13)</td>
<td>Collateral Loans</td>
<td>0.0500</td>
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<td>01 (14)</td>
<td>Mortgages</td>
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<tr>
<td>01 (15)</td>
<td>NAIC 02 Unaffiliated Preferred Stock</td>
<td>0.0100</td>
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<tr>
<td>01 (16)</td>
<td>NAIC 03 Unaffiliated Preferred Stock</td>
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<tr>
<td>01 (17)</td>
<td>NAIC 04 Unaffiliated Preferred Stock</td>
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<td>01 (18)</td>
<td>NAIC 05 Unaffiliated Preferred Stock</td>
<td>0.1000</td>
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<tr>
<td>04 (19)</td>
<td>NAIC 02 Hybrid Securities</td>
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<td>$0</td>
<td></td>
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<tr>
<td>04 (20)</td>
<td>NAIC 03 Hybrid Securities</td>
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<td>04 (21)</td>
<td>NAIC 04 Hybrid Securities</td>
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<td>04 (22)</td>
<td>NAIC 05 Hybrid Securities</td>
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<tr>
<td>01 (19)</td>
<td>Other Long-Term Invested Assets</td>
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<td>01 (20)</td>
<td>NAIC 02 Working Capital Finance Investments</td>
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<td>State Non-Guaranteed Low Income Housing Tax Credits</td>
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<tr>
<td>01 (25)</td>
<td>All Other Low Income Housing Tax Credits</td>
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<td>01 (26)</td>
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<td>01 (27)</td>
<td>Total of Issuer = Lines (1) through (26)</td>
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</table>

Denotes items that must be manually entered on filing software.

Page numbers have been updated based on proposal 2020-07-H that will be considered by the HRBCWG on the Oct. 29, 2020 call.
### CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE

#### H0 - INSURANCE AFFILIATES AND MISC. OTHER AMOUNTS

<table>
<thead>
<tr>
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<th>RBC Amount</th>
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<tbody>
<tr>
<td>(1) Off-Balance Sheet Items</td>
<td>XR005, Off-Balance Sheet Page, Line (21)</td>
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<td>(2) Directly Owned Insurer Subject to RBC</td>
<td>XR003, Affiliates Page, Line (1)</td>
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<tr>
<td>(3) Indirectly Owned Insurer Subject to RBC</td>
<td>XR003, Affiliates Page, Line (2)</td>
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<tr>
<td>(4) Directly Owned Health Entity Subject to RBC</td>
<td>XR003, Affiliates Page, Line (3)</td>
</tr>
<tr>
<td>(5) Indirectly Owned Health Entity Subject to RBC</td>
<td>XR003, Affiliates Page, Line (4)</td>
</tr>
<tr>
<td>(6) Directly Owned Alien Insurer</td>
<td>XR003, Affiliates Page, Line (7)</td>
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<tr>
<td>(7) Indirectly Owned Alien Insurers</td>
<td>XR003, Affiliates Page, Line (8)</td>
</tr>
<tr>
<td>(8) Total H0</td>
<td>Sum Lines (1) through (7)</td>
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#### H1 - ASSET RISK - OTHER

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<td>(9) Investment Affiliates</td>
<td>XR003, Affiliates Page, Line (5)</td>
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<tr>
<td>(10) Holding Company Excess of Subsidiaries</td>
<td>XR003, Affiliates Page, Line (6)</td>
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<tr>
<td>(11) Investment in Parent</td>
<td>XR003, Affiliates Page, Line (9)</td>
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<tr>
<td>(12) Other Affiliates</td>
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<tr>
<td>(13) Fair Value Excess Affiliate Common Stock</td>
<td>XR003, Affiliates Page, Line (11)</td>
</tr>
<tr>
<td>(14) Fixed Income Assets</td>
<td>XR006, Off-Balance Sheet Collateral, Lines (27) + (37) + (38) + (39) + XR008, Fixed Income Assets Page Line (51)</td>
</tr>
<tr>
<td>(15) Replication &amp; Mandatory Convertible Securities</td>
<td>XR009, Replication/MCS Page, Line (999999)</td>
</tr>
<tr>
<td>(16) Unaffiliated Preferred Stock and Hybrid Securities</td>
<td>XR006, Off-Balance Sheet Collateral, Line (34) + XR010, Equity Assets Page, Line (7)</td>
</tr>
<tr>
<td>(17) Unaffiliated Common Stock</td>
<td>XR006, Off-Balance Sheet Collateral, Line (35) + XR010, Equity Assets Page, Line (12)</td>
</tr>
<tr>
<td>(18) Property &amp; Equipment</td>
<td>XR006, Off-Balance Sheet Collateral, Line (36) + XR011, Prop/Equip Assets Page, Line (9)</td>
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<tr>
<td>(19) Asset Concentration</td>
<td>XR012, Grand Total Asset Concentration Page, Line (27)</td>
</tr>
<tr>
<td>(20) Total H1</td>
<td>Sum Lines (9) through (19)</td>
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#### H2 - UNDERWRITING RISK

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<tr>
<td>(21) Net Underwriting Risk</td>
<td>XR013, Underwriting Risk Page, Line (21)</td>
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<tr>
<td>(22) Other Underwriting Risk</td>
<td>XR015, Underwriting Risk Page, Line (25.3)</td>
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<tr>
<td>(23) Disability Income</td>
<td>XR015, Underwriting Risk Page, Lines (26.3) + (27.3) + (28.3) + (29.3) + (30.6) + (31.3) + (32.3)</td>
</tr>
<tr>
<td>(24) Long-Term Care</td>
<td>XR016, Underwriting Risk Page, Line (41)</td>
</tr>
<tr>
<td>(25) Limited Benefit Plans</td>
<td>XR017, Underwriting Risk Page, Lines (42.2) + (43.6) + (44)</td>
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<tr>
<td>(26) Premium Stabilization Reserve</td>
<td>XR017, Underwriting Risk Page, Line (45)</td>
</tr>
<tr>
<td>(27) Total H2</td>
<td>Sum Lines (21) through (26)</td>
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Page numbers have been updated based on proposal 2020-07-H that will be considered by the HRBCWG on the Oct. 29, 2020 call.
CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE

<table>
<thead>
<tr>
<th>RBC Amount</th>
<th>XR020, Credit Risk Page, Line (17)</th>
<th>XR020, Credit Risk Page, Line (24)</th>
<th>XR021, Credit Risk Page, Line (30)</th>
<th>Sum Lines (28) through (30)</th>
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<tr>
<td>(1)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>(2)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<table>
<thead>
<tr>
<th>RBC Amount</th>
<th>H0 + Square Root of (H1² + H2² + H3² + H4²)</th>
<th>0.030 x Line (37)</th>
<th>Company Records</th>
<th>Line (38) - (39) (Not less than zero)</th>
<th>Lines (37) + (40)</th>
<th>.50 x Line (41)</th>
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</thead>
<tbody>
<tr>
<td>(3)</td>
<td>$0</td>
<td>$0</td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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</tbody>
</table>

Page numbers have been updated based on proposal 2020-07-H that will be considered by the HRBCWG on the Oct. 29, 2020 call.
ASSETS
PR006 – PR014

PR006 - Bonds and Bond Size Factor Adjustment

Basis of General Bond Factors

The bond risk factors for investment grade bonds (NAIC Designation Category 1.A – 2.C) are based on cash flow modeling. Each bond of a portfolio was annually tested for default (based on a “roll of the dice”) where the default probability varies by NAIC Designation category and that year’s economic environment. The default probabilities were based on historical data intended to reflect a complete cycle of favorable and unfavorable credit environments. The risk of default was measured over a 5-year time horizon, selected considering the duration of property/casualty assets and liabilities.

The factors for NAIC Designation Category 3.A to 6 recognize that these non-investment grade bonds are reported at the lower of amortized cost or fair value. These bond risk factors are based on the market value fluctuation for each of the NAIC designation category compared to the market value fluctuation of stocks during the 2008-2009 financial crisis.

The bond risk factors are selected with consideration of the effect of the bond size factors.

Bond Size Factor

The bond factors assume a portfolio of 802 issuers. The size factor reflects that the risk increases as the number of bond issuers decreases. The bond size factor adjusts the computed RBC for those bonds that are subject to the size factor to more accurately reflect the risk.

The bond size factor is to be multiplied by the risk-based capital of the bonds subject to the size factor. This calculation produces the additional RBC required for a portfolio that has 801 or less bonds in it. Portfolios with 803 or more issuers will receive a discount. The bond size factor was developed as a step factor (as in a tax table) so that the overall factor decreases as the portfolio size increases. The bond size factors are the same for property/casualty and life insurance RBC Formulas.

Bonds should be aggregated by issuer (the first six digits of the CUSIP number should be used for aggregation). In determining the total number of issuers, do not count:

- U.S. government bonds that are direct and guaranteed and backed by the full faith and credit of the U.S. government, other U.S. Government Obligations, and NAIC U.S. Government Money Market Fund List which receive a zero factor (Definitions of these categories are in the Annual Statement Instructions).

The calculation shown below will not appear in the software but will be calculated automatically. However, you must enter the total number of issuers in the appropriate field on the RBC filing software. If you leave this field blank, the program will assume that there are less than 10 issuers and will default to the maximum bond size factor adjustment. The calculation to derive the bond size factor is:

<table>
<thead>
<tr>
<th>Source</th>
<th>No of Issuers</th>
<th>Wgtd Issuers</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 10</td>
<td>Co Records</td>
<td>X 7.8=</td>
</tr>
<tr>
<td>Next 90</td>
<td>Co Records</td>
<td>X 1.75=</td>
</tr>
<tr>
<td>Next 100</td>
<td>Co Records</td>
<td>X 1.0 =</td>
</tr>
<tr>
<td>Next 300</td>
<td>Co Records</td>
<td>X 0.8 =</td>
</tr>
<tr>
<td>Over 500</td>
<td>Co Records</td>
<td>X 0.75 =</td>
</tr>
<tr>
<td>Total</td>
<td>Co Records</td>
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</tbody>
</table>

Size Factor = Total Weighted Issuers/Total No of Issuers less 1
PR007 - Unaffiliated Preferred and Common Stock

Unaffiliated Preferred Stock

Detailed information on unaffiliated preferred stocks is found in Schedule D Part 2 Section 1 of the annual statement. The preferred stocks must be broken out by NAIC Designation (NAIC 01 through NAIC 06) and these individual groups are to be entered in the appropriate lines of the RBC software. The total amount of unaffiliated preferred stock reported should equal annual statement P2 L2.1 C3 less any affiliated preferred stock in Schedule D-Summary by Country C1 L18.

Unaffiliated Common Stock

The factor for other unaffiliated common stock is based on studies that indicate a 10 percent to 12 percent factor is needed to provide capital to cover approximately 95 percent of the greatest losses in common stock value over a one-year future period. The higher factor of 15 percent contained in the formula reflects the increased risk when testing a period in excess of one year. This factor assumes capital losses are unrealized and not subject to favorable tax treatment at the time loss in fair value occurs.

The total of all unaffiliated common stock reported should be equal to the total value of common stock in Schedule D-Summary by Country C1 L25 less the sum of Schedule D-Summary by Country C1 L24 and PR007, Column 1, Line 18.

PR009 - Miscellaneous Assets

Collateral loans and write-ins for invested assets are generally a small proportion of total portfolio value. A factor of 5 percent is consistent with other risk-based capital formulas studied by the working group.

The factor for cash is 0.3%. It is recognized that there is a small risk related to possible insolvency of the bank where cash deposits are held. This factor was based on the original unaffiliated NAIC 01 bond risk factor prior to the increased granularity of the NAIC Designation Categories in 2021, and reflects the short-term nature of this risk. The required risk-based capital for cash will not be less than zero, even if the company’s cash position is negative.

If the book/adjusted carrying value of Aggregate Write-ins for Invested Assets (Page 2, Line 11, Column 3 of the annual statement) is less than zero, the RBC amount will be zero.

The Short-Term Investments to be included in this section are those short-term investments not reflected elsewhere in the formula. The 0.3% factor is equal to the factor for cash. The amount entered for short-term bonds should equal the total short-term investments found in Schedule DA Part 1 C7 L8399999. This amount is subtracted from the total of short-term investments, as they are captured with bonds on PR006.

PR011 - Asset Concentration

The purpose of the concentration factor is to reflect the additional risk of high concentrations in single exposures (represented by an issuer of a security or a mortgage borrower, etc.). The concentration factor basically doubles the risk-based capital factor (up to a maximum of 30 percent) of the 10 largest asset exposures excluding various low-risk categories or categories which already have a 30 percent factor. Since the risk-based capital of the assets included in the concentration factor has already been counted once in the basic formula, this factor itself only serves to add an additional risk-based capital requirement on these assets.

Concentrated investments in certain types of assets are not expected to represent an additional risk over and above the general risk of the asset itself. Therefore, prior to determining the 10 largest issuers, you should exclude those assets that are exempt from the asset concentration factor. Asset types that are excluded from the calculation include: NAIC 06 bonds and preferred stock, affiliated common stock, affiliated preferred stock, property and equipment, U.S. government guaranteed bonds, NAIC 01 bonds or preferred stock, any other asset categories with risk-based capital factors less that 1 percent, and investment companies (mutual funds) and common trust funds that are diversified within the meaning of the Investment Company Act of 1940 [Section 5(b) (1)]. The pro rata share of individual securities within an investment company (mutual fund) or common trust fund are to be included in the determination of concentrated investments, subject to the exclusions identified.
With respect to investment companies (mutual funds) and common trust funds, the reporting company is responsible for maintaining the appropriate documentation as evidence that such is diversified within the meaning of the Investment Company Act and provide this information upon request of the commissioner, director or superintendent of the department of insurance. The reporting company is also responsible for maintaining a listing of the individual securities and corresponding book/adjusted carrying values making up its investment companies (mutual funds) and common trust funds portfolio, in order to determine whether a concentration charge is necessary. This information should be provided to the commissioner, director or superintendent upon request.

The assets that ARE INCLUDED in the calculation are divided into two categories – Fixed Income Assets and Equity Assets. The following asset types should be aggregated to determine the 10 largest issuers:

**FIXED INCOME ASSETS**
- Bonds – NAIC Designation Category 2.A
- Bonds – NAIC Designation Category 2.B
- Bonds – NAIC Designation Category 2.C
- Bonds – NAIC Designation Category 3.A
- Bonds – NAIC Designation Category 3.B
- Bonds – NAIC Designation Category 3.C
- Bonds – NAIC Designation Category 4.A
- Bonds – NAIC Designation Category 4.B
- Bonds – NAIC Designation Category 4.C
- Bonds – NAIC Designation Category 5.A
- Bonds – NAIC Designation Category 5.B
- Bonds – NAIC Designation Category 5.C
- Collateral Loans
- Mortgage Loans
- Working Capital Finance Investments – NAIC 02
- Federal Guaranteed Low Income Housing Tax Credits
- Federal Non-Guaranteed Low Income Housing Tax Credits
- State Guaranteed Low Income Housing Tax Credits
- State Non-Guaranteed Low Income Housing Tax Credits
- All Other Low Income Housing Tax Credits

**EQUITY ASSETS**
- Unaffiliated Preferred Stock – NAIC 02
- Unaffiliated Preferred Stock – NAIC 03
- Unaffiliated Preferred Stock – NAIC 04
- Unaffiliated Preferred Stock – NAIC 05
- Unaffiliated Common Stock
- Investment Real Estate
- Encumbrances on Inv. Real Estate
- Schedule BA Assets (excluding Collateral Loans)
- Receivable for Securities
- Aggregate Write-Ins for Invested Assets
- Derivatives

The name of each of the largest 10 issuers is entered at the top of the table and the appropriate statement amounts are entered in C(2) Ls (01) through (20) for fixed income assets and C(2), Ls (22) through (32) for equity assets. Aggregate all similar asset types before entering the amount in C(2). For instance, if you own five separate $1,000,000 NAIC 03.A bonds from Issuer #1, enter $5,000,000 in C(2) L(02) – NAIC 03.A Unaffiliated Bonds.

**OFF-BALANCE SHEET COLLATERAL AND SCHEDULE DL, PART 1 ASSETS**

Security lending programs are required to maintain collateral. Some entities post the collateral supporting security lending programs on their financial statements, and incur the related risk charges on those assets. Other entities have collateral that is not reported on their financial statements. While not recorded on the financial statements of the company, such collateral has risks that are not otherwise captured in the RBC formula.
The collateral in these accounts is maintained by a third party (typically a bank or other agent). The collateral agent maintains on behalf of the company detail asset listings of the collateral assets, and this data is the source for preparation of this schedule. The company should maintain such asset listings, at a minimum CUSIP, market value, book/carrying value, and maturity date.

The asset risk charges are derived from existing RBC factors for bonds, preferred and common stocks, other invested assets, and invested assets not otherwise classified (aggregate write-ins).

**Specific Instructions for Application of the Formula**


Off-balance sheet collateral included in General Interrogatories Part 1, Lines 24.05 and 24.06 of the Annual Statement should agree with Line (41), Column (1).

**Lines (1) through (26) – Bonds**
Bond factors described on PR006 – Bonds and Bond Size Factor Adjustment

**Line (28) through (33) – Preferred Stocks**
Preferred stock factors described on PR007 – Unaffiliated Preferred and Common Stock

**Lines (35) – Common Stock**
Common stock factors described on PR007 – Unaffiliated Preferred and Common Stock

**Line (36) – Real Estate and Schedule BA - Other Invested Assets**
Real Estate and other invested asset factors described on PR008 – Other Long-Term Assets

**Line (37) – Other Invested Assets**
Other invested assets factors described on PR009 – Miscellaneous Assets

**Line (38) – Mortgage Loans on Real Estate**
Mortgage Loans on Real Estate factor described on PR009 – Miscellaneous Assets

**Line (39) – Cash, Cash Equivalents and Short-Term Investments**
Cash, Cash Equivalents and Short-Term Investments factors described on PR007 – Unaffiliated Preferred, Common Stock and Hybrid Securities and PR009 – Miscellaneous Assets
### Annual Statement Source

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<tr>
<th>Source Description</th>
<th>Schedule</th>
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<tr>
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<td>Short-Term Investments Schedule DA, Part 1 Book/Adjusted Carrying Value</td>
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<td>Cash Equivalents Schedule E, Part 2 Book/Adjusted Carrying Value</td>
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### NAIC Designation Category 1.A - U.S. Government Full Faith and Credit, Other U.S. Government Obligations, and NAIC U.S. Government Money Market Fund List (Refer to A/S Instructions)

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### Total NAIC 01 Bonds

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### NAIC Designation Category 2.A - NAIC Designation Category 2.B - NAIC Designation Category 2.C

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### Total NAIC 02 Bonds

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### Total NAIC 03 Bonds

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### Total NAIC 04 Bonds

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### NAIC Designation Category 5.A - NAIC Designation Category 5.B - NAIC Designation Category 5.C

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### Total NAIC 05 Bonds

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### Total NAIC 06 Bonds

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### Subtotal - Bonds Subject to Bond Size Factor

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### Number of Issuers

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### Bond Size Factor

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### Bond Size Factor RBC

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<td>C(15) x C(27) x C(59)</td>
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### Total Bonds RBC

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<td>L(27) x L(59)</td>
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### Denotes items that must be vendor linked.

### Denotes items that must be manually entered on the filing software.
### Unaffiliated Preferred and Common Stock and Hybrid Securities

**Unaffiliated Preferred Stock**

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<tr>
<th>Unaffiliated Preferred Stock</th>
<th>Annual Statement Source</th>
<th>(1) Book/Adjusted Carrying Value</th>
<th>(2) Factor</th>
<th>(3) RBC Requirement</th>
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<tr>
<td>(1) NAIC 01 Preferred Stock</td>
<td>Sch D Pt 2 Sn 1</td>
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<td>0.003</td>
<td>0</td>
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<tr>
<td>(2) NAIC 02 Preferred Stock</td>
<td>Sch D Pt 2 Sn 1</td>
<td>0</td>
<td>0.010</td>
<td>0</td>
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<tr>
<td>(3) NAIC 03 Preferred Stock</td>
<td>Sch D Pt 2 Sn 1</td>
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<td>0.020</td>
<td>0</td>
</tr>
<tr>
<td>(4) NAIC 04 Preferred Stock</td>
<td>Sch D Pt 2 Sn 1</td>
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<td>0.045</td>
<td>0</td>
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<tr>
<td>(5) NAIC 05 Preferred Stock</td>
<td>Sch D Pt 2 Sn 1</td>
<td>0</td>
<td>0.100</td>
<td>0</td>
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<tr>
<td>(6) NAIC 06 Preferred Stock</td>
<td>Sch D Pt 2 Sn 1</td>
<td>0</td>
<td>0.300</td>
<td>0</td>
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<tr>
<td>(7) <strong>SUBTOTAL - UNAFFILIATED PREFERRED STOCK</strong></td>
<td>Sum of Ls(1) through (6)</td>
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(should equal P2 L2.1 C3 less Sch D-Sum C1 L18)

| (8) NAIC 01 Hybrid Securities | Sch D Pt 1A Sn 1 C(7) L (7.1) | 4 | 4.003 | 0 |
| (9) NAIC 02 Hybrid Securities | Sch D Pt 1A Sn 1 C(7) L (7.2) | 4 | 4.010 | 0 |
| (10) NAIC 03 Hybrid Securities | Sch D Pt 1A Sn 1 C(7) L (7.3) | 4 | 4.020 | 0 |
| (11) NAIC 04 Hybrid Securities | Sch D Pt 1A Sn 1 C(7) L (7.4) | 4 | 4.045 | 0 |
| (12) NAIC 05 Hybrid Securities | Sch D Pt 1A Sn 1 C(7) L (7.5) | 4 | 4.100 | 0 |
| (13) NAIC 06 Hybrid Securities | Sch D Pt 1A Sn 1 C(7) L (7.6) | 4 | 4.300 | 0 |
| (14) **SUBTOTAL - HYBRID SECURITIES** | Sum of Ls(8) through (13) | 4 | | |

(15) **Total Unaffiliated Preferred Stock and Hybrid Securities** Line (7) + Line (14)

---

### Unaffiliated Common Stock

<table>
<thead>
<tr>
<th>Unaffiliated Common Stock</th>
<th>Sch D - Summary C1 L25</th>
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</thead>
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<tr>
<td>(8) Total Common Stock</td>
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<tr>
<td>(9) Affiliated Common Stock</td>
<td>Sch D - Summary C1 L24</td>
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<tr>
<td>(10) Non-Admitted Unaffiliated Common Stock</td>
<td>P2 C2 L2.2 - Sch D Pt6 Sn1 C10 L1899999</td>
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<tr>
<td>(11) Admitted Unaffiliated Common Stock</td>
<td>L(8) - L(9) - L(10)</td>
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<tr>
<td>(12) Fair Value Excess Affiliated Common Stock</td>
<td>PR003 C(14) L(9999999)</td>
</tr>
<tr>
<td>(13) Total Unaffiliated Common Stock</td>
<td>L(11) + L(12)</td>
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</tbody>
</table>
## MISCELLANEOUS ASSETS  PR009

| (1)  | Receivable for Securities | P2C3L9 | 0 | 0.025 | 0 |
| (2)  | Aggregate W/I for Invest Assets | P2C3 L11 | 0 | 0.050 | 0 |
| (3)  | Cash | P2 L5, inside amt 1 | 0 | 0.003 | 0 |
| (4)  | Cash Equivalents | P2 L5, inside amt 2 | 0 | 0 | 0 |
| (5)  | Less: Cash Equivalents, Total Bonds | Sch E Pt 2 C7 L8399999 | 0 | 0 | 0 |
| (6)  | Less: Exempt Money Market Mutual Funds as Identified by SVO | Sch E Pt 2 C7 L8599999 | 0 | 0 | 0 |
| (7)  | Net Cash Equivalents | L(4)+L(5)+L(6) | 0 | 0.003 | 0 |
| (8)  | Short-Term Investments | P2 L5, inside amt 3 | 0 | 0 | 0 |
| (9)  | Short-Term Bonds | Sch DA Pt 1 C7 L8399999 | 0 | 0 | 0 |
| (10) | Total Other Short-Term Investments | L(8)+L(9) | 0 | 0.003 | 0 |
| (11) | Collateral Loans | Sch BA Pt 1 C7 L2999999+3099999 | 0 | 0 | 0 |
| (12) | Less: Non-Admitted Collateral Loans | P2 L8 C2 in part | 0 | 0.050 | 0 |
| (13) | Net Admitted Collateral Loans | L(11) - L(12) | 0 | 0.050 | 0 |
| (14) | Derivatives | P2C3 L7 | 0 | 0 | 0 |
| (15) | Total Miscellaneous Assets | L(1)+L(2)+L(3)+L(7)+L(10)+L(13)+L(14) | 0 | 0 | 0 |

* These bonds appear in Schedule D Part 1A Section 1 and are already recognized in the Bonds portion of the formula.

Denotes items that must be manually entered on the filing software.
| (1) | NAIC Designation Category 2.A Bonds | (2) | 0 | 0.0000 | 0 |
| (2) | NAIC Designation Category 2.B Bonds | (3) | 0 | 0.0000 | 0 |
| (3) | NAIC Designation Category 2.C Bonds | (4) | 0 | 0.0000 | 0 |
| (4) | NAIC Designation Category 3.A Bonds | (5) | 0 | 0.0000 | 0 |
| (5) | NAIC Designation Category 3.B Bonds | (6) | 0 | 0.0000 | 0 |
| (6) | NAIC Designation Category 3.C Bonds | (7) | 0 | 0.0000 | 0 |
| (7) | NAIC Designation Category 4.A Bonds | (8) | 0 | 0.0000 | 0 |
| (8) | NAIC Designation Category 4.B Bonds | (9) | 0 | 0.0000 | 0 |
| (9) | NAIC Designation Category 4.C Bonds | (10) | 0 | 0.0000 | 0 |
| (10) | NAIC Designation Category 5.A Bonds | (11) | 0 | 0.0000 | 0 |
| (11) | NAIC Designation Category 5.B Bonds | (12) | 0 | 0.0000 | 0 |
| (12) | NAIC Designation Category 5.C Bonds | (13) | 0 | 0.0500 | 0 |
| (13) | Collateral Loans | (14) | 0 | 0.0500 | 0 |
| (14) | Mortgage Loans | (15) | 0 | 0.0125 | 0 |
| (15) | NAIC 02 Working Capital Finance Investments | (16) | 0 | 0.0014 | 0 |
| (16) | Federal Guaranteed Low Income Housing Tax Credits | (17) | 0 | 0.0260 | 0 |
| (17) | Federal Non-Guaranteed Low Income Housing Tax Credits | (18) | 0 | 0.0014 | 0 |
| (18) | State Guaranteed Low Income Housing Tax Credits | (19) | 0 | 0.0260 | 0 |
| (19) | State Non-Guaranteed Low Income Housing Tax Credits | (20) | 0 | 0.1500 | 0 |
| (20) | AllOther Low Income Housing Tax Credits | (21) | 0 | 0 | 0 |
| (21) | SUBTOTAL - FIXED INCOME | (22) | 0 | 0.0100 | 0 |
| (22) | NAIC 02 Unaffiliated Preferred Stock | (23) | 0 | 0.0200 | 0 |
| (23) | NAIC 03 Unaffiliated Preferred Stock | (24) | 0 | 0.0450 | 0 |
| (24) | NAIC 04 Unaffiliated Preferred Stock | (25) | 0 | 0.0100 | 0 |
| (25) | NAIC 05 Unaffiliated Preferred Stock | (26) | 0 | 0.0100 | 0 |
| (26) | NAIC 02 Hybrid Securities | (27) | 0 | 0.0200 | 0 |
| (27) | NAIC 03 Hybrid Securities | (28) | 0 | 0.0450 | 0 |
| (28) | NAIC 04 Hybrid Securities | (29) | 0 | 0.0100 | 0 |
| (29) | NAIC 05 Hybrid Securities | (30) | 0 | 0.0250 | 0 |
| (30) | Property Held For Production of Income or For Sale Excluding Home Office | (31) | 0 | 0.0500 | 0 |
| (31) | Property Held For Production of Income or For Sale Encumbrances Excluding Home Office | (32) | 0 | 0.0500 | 0 |
| (32) | Schedule BA Assets | (33) | 0 | 0.1500 | 0 |
| (33) | Receivable for Securities | (34) | 0 | 0 | 0 |
| (34) | Total - Issuer #1 (L21+L33) | 0 | 0 | 0 | 0 |

Denotes items that must be manually entered on the filing software.
# OFF-BALANCE SHEET COLLATERAL AND SCHEDULE DL, PART 1 ASSETS PR015

## Asset Category

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<th>(2) Schedule DL, Part 1</th>
<th>(3) Subtotal</th>
<th>(4) Factor</th>
<th>RBC Requirement</th>
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<td>Current Value</td>
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<td>(31) NAIC 04 Unaffiliated Preferred Stock</td>
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<td>(33) NAIC 06 Unaffiliated Preferred Stock</td>
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<td>(34) Total Unaffiliated Preferred Stock</td>
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<td>(35) Unaffiliated Common Stock</td>
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<td>(36) Real Estate and Schedule BA - Other Invested Assets</td>
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<td>(38) Mortgage Loans on Real Estate</td>
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<td>0.050</td>
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<tr>
<td>(39) Cash, Cash Equivalents and Short-Term Investments (Not reported as Bonds above)</td>
<td>Company Records</td>
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<td>0.003</td>
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<td>(40) Total</td>
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Denotes items that must be manually entered on the filing software.
### CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE

**R0**

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<tr>
<td>Affiliated US P&amp;C Insurers - Indirectly Owned</td>
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<td>Affiliated US Life Insurers - Directly Owned</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Affiliated US Life Insurers - Indirectly Owned</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affiliated US Health Insurer - Directly Owned</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affiliated US Health Insurer - Indirectly Owned</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affiliated Alien Insurers - Directly Owned</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affiliated Alien Insurers - Indirectly Owned</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misc Off-Balance Sheet - Non-Controlled Assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misc Off-Balance Sheet - Guarantees for Affiliates</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misc Off-Balance Sheet - Contingent Liabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misc Off-Balance Sheet - SSAP No.101 Par. 11A DTA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misc Off-Balance Sheet - SSAP No.101 Par. 11B DTA</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Total R0</strong></td>
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**R1**

<table>
<thead>
<tr>
<th>Description</th>
<th>PR006</th>
<th>L(2)</th>
<th>C(2)</th>
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<tbody>
<tr>
<td>NAIC 01 U.S. Government Agency Bonds</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Bonds Subject to Size Factor</td>
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<tr>
<td>Bond Size Factor RBC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Off-balance Sheet Collateral &amp; Sch DL, PT1 - Total Bonds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Off-balance Sheet Collateral &amp; Sch DL, PT1 - Cash, Cash Equi, non-govt MMF</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Long-Term Assets - Mortgage Loans, LEPI, &amp; WCF</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Misc. - Cash Equivalents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misc Assets - Collateral Loans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misc Assets - Cash</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misc Assets - Cash Equivalents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Replication - Synthetic Asset: One Half</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asset Concentration RBC - Fixed Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total R1</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
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**Grand Total**

<table>
<thead>
<tr>
<th>Description</th>
<th>PR010</th>
<th>L(999,999)</th>
<th>C(7)</th>
<th>0</th>
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</thead>
<tbody>
<tr>
<td>Replication - Synthetic Asset: One Half</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

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## Calculation of Total Risk-Based Capital After Covariance (PR031 R2-R3)

### R2 - Asset Risk - Equity

<table>
<thead>
<tr>
<th>PRBC O&amp;I Reference</th>
<th>RBC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>R2 - Asset Risk - Equity</td>
<td></td>
</tr>
<tr>
<td>(27) Common - Affiliate Investment Subsidiary</td>
<td>PR004 L(7)C(2)</td>
</tr>
<tr>
<td>(28) Common - Affiliate Hold. Company in excess of Ins. Subs.</td>
<td>PR004 L(10)C(2)</td>
</tr>
<tr>
<td>(29) Common - Investment in Parent</td>
<td>PR004 L(11)C(2)</td>
</tr>
<tr>
<td>(30) Common - Affl US P&amp;C Not Subj to RBC</td>
<td>PR004 L(12)C(2)</td>
</tr>
<tr>
<td>(31) Common - Affil US Life Not Subj to RBC</td>
<td>PR004 L(13)C(2)</td>
</tr>
<tr>
<td>(32) Common - Affil US Health Insurer Not Subj to RBC</td>
<td>PR004 L(14)C(2)</td>
</tr>
<tr>
<td>(33) Common - Affil Non-insurer</td>
<td>PR004 L(15)C(2)</td>
</tr>
<tr>
<td>(34) Preferred - Aff'd Invest Sub</td>
<td>PR004 L(7)C(3)</td>
</tr>
<tr>
<td>(35) Preferred - Aff'd Hold. Co. in excess of Ins. Subs.</td>
<td>PR004 L(10)C(3)</td>
</tr>
<tr>
<td>(36) Preferred - Investment in Parent</td>
<td>PR004 L(11)C(3)</td>
</tr>
<tr>
<td>(37) Preferred - Affil US P&amp;C Not Subj to RBC</td>
<td>PR004 L(12)C(3)</td>
</tr>
<tr>
<td>(38) Preferred - Affil US Life Not Subj to RBC</td>
<td>PR004 L(13)C(3)</td>
</tr>
<tr>
<td>(39) Preferred - Affil US Health Insurer Not Subj to RBC</td>
<td>PR004 L(14)C(3)</td>
</tr>
<tr>
<td>(40) Preferred - Affil Non-insurer</td>
<td>PR004 L(15)C(3)</td>
</tr>
<tr>
<td>(41) Unaffiliated Preferred Stock and Hybrid Securities</td>
<td>PR007 L(7)C(2)+PR015 L(34)C(4)</td>
</tr>
<tr>
<td>(42) Unaffiliated Common Stock</td>
<td>PR007 L(2)C(2)+PR015 L(35)C(4)</td>
</tr>
<tr>
<td>(43) Other Long-Term Assets - Real Estate</td>
<td>PR008 L(7)C(2)</td>
</tr>
<tr>
<td>(44) Other Long-Term Assets - Schedule BA Assets</td>
<td>PR008 L(19)C(2)+PR015 L(36)+L(37)C(4)</td>
</tr>
<tr>
<td>(45) Misc Assets - Receivable for Securities</td>
<td>PR009 L(1)C(2)</td>
</tr>
<tr>
<td>(46) Misc Assets - Aggregate Write-ins for Invested Assets</td>
<td>PR009 L(2)C(2)</td>
</tr>
<tr>
<td>(47) Misc Assets - Derivatives</td>
<td>PR009 L(14)C(2)</td>
</tr>
<tr>
<td>(48) Replication - Synthetic Asset: One Half</td>
<td>PR010 L(9999999)C(2)</td>
</tr>
<tr>
<td>(49) Asset Concentration RBC - Equity</td>
<td>PR011 L(34)C(3)</td>
</tr>
</tbody>
</table>

### Total R2

\[ \text{Total R2} = \sum_{\text{all terms}} \text{RBC Amount} \]

### Total R2 Calculation

\[ \text{Total R2} = \text{R2 - Asset Risk - Equity} \]

### R3 - Asset Risk - Credit

<table>
<thead>
<tr>
<th>PRBC O&amp;I Reference</th>
<th>RBC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>R3 - Asset Risk - Credit</td>
<td></td>
</tr>
<tr>
<td>(51) Other Credit RBC</td>
<td>PR012 L(8)-L(1)-L(2)C(2)</td>
</tr>
<tr>
<td>(52) One half of Rein Recoverables</td>
<td>0.5 x (PR012 L(1)+L(2)C(2))</td>
</tr>
<tr>
<td>(53) Other half of Rein Recoverables</td>
<td>0, otherwise, R3 L(52)</td>
</tr>
<tr>
<td>(54) Health Credit Risk</td>
<td>PR013 L(12)C(2)</td>
</tr>
</tbody>
</table>

### Total R3

\[ \text{Total R3} = \sum_{\text{all terms}} \text{RBC Amount} \]

### Total R3 Calculation

\[ \text{Total R3} = \text{R3 - Asset Risk - Credit} \]
### CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE  

<table>
<thead>
<tr>
<th>R4 - Underwriting Risk - Reserves</th>
<th>PRBC O&amp;I Reference</th>
<th>RBC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(56) One half of Reinsurance RBC</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>(57) Total Adjusted Unpaid Loss/Expense Reserve RBC</td>
<td>PR0017 L(15)C(20)</td>
<td>0</td>
</tr>
<tr>
<td>(58) Excessive Premium Growth - Loss/Expense Reserve</td>
<td>PR016 L(13) C(8)</td>
<td>0</td>
</tr>
<tr>
<td>(59) A&amp;H Claims Reserves Adjusted for LCF</td>
<td>PR024 L(5) C(2) + PR023 L(6) C(4)</td>
<td>0</td>
</tr>
<tr>
<td>(60) Total R4</td>
<td>L(56)+L(57)+L(58)+L(59)</td>
<td>0</td>
</tr>
</tbody>
</table>

| R5 - Underwriting Risk - Net Written Premium | |
|---------------------------------------------|---------------------|------------|
| (61) Total Adjusted NWP RBC | PR018 L(15)C(20) | 0          |
| (62) Excessive Premium Growth - Written Premiums Charge | PR016 L(14) C(8) | 0          |
| (63) Total Net Health Premium RBC | PR022 L(2) C(2) | 0          |
| (64) Health Stabilization Reserves | PR025 L(8)C(2) + PR023 L(3) C(2) | 0          |
| (65) Total R5 | L(61)+L(62)+L(63)+L(64) | 0          |

| Re cat- Catastrophe Risk | |
|--------------------------|---------------------|------------|
| (66) Total Rcat | PR027 L(3) C(1) | 0          |
| (67) Total RBC After Covariance Before Basic Operational Risk = R0+SQRT(R1^2+R2^2+R3^2+R4^2+R5^2+Rcat^2) | | 0 |

<table>
<thead>
<tr>
<th>Basic Operational Risk = 0.030 x L(67)</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-4a of U.S. Life Insurance Subsidiaries (from Company records)</td>
<td></td>
</tr>
<tr>
<td>Net Basic Operational Risk = Line (68) - Line (69) (Not less than zero)</td>
<td></td>
</tr>
<tr>
<td>Total RBC After Covariance including Basic Operational Risk = L(67)+ L(68)</td>
<td></td>
</tr>
</tbody>
</table>

| Authorized Control Level RBC including Basic Operational Risk = .5 x L(71) | |

---

**Notes:**
- **R0** = R1 + R2 + R3 + R4 + R5 + Rcat
- **R1**, **R2**, **R3**, **R4**, **R5**, **Rcat** are calculated as per previous sections.
- **Basic Operational Risk** is determined by a company's records.
- **Net Basic Operational Risk** is calculated as the difference between total RBC and basic operational risk, not less than zero.
- **Authorized Control Level RBC** includes basic operational risk.
Capital Adequacy (E) Task Force
RBC Proposal Form

[ ] Catastrophe Risk (E) Subgroup  [ ] Investment RBC (E) Working Group  [ ] Longevity Risk (A/E) Subgroup
[ ] C3 Phase II/ AG43 (E/A) Subgroup  [ ] P/C RBC (E) Working Group

DATE: 1-28-21

CONTACT PERSON: Crystal Brown
TELEPHONE: 816-783-8146
EMAIL ADDRESS: cbrown@naic.org
ON BEHALF OF: Health RBC (E) Working Group
NAME: Steve Drutz
TITLE: Chief Financial Analyst/Chair
AFFILIATION: WA Office of Insurance Commissioner
ADDRESS: PO Box 40255
       Olympia, WA 98504-0255

FOR NAIC USE ONLY
Agenda Item # 2021-02-CA
Year 2021

DISPOSITION
[ ] ADOPTED
[ ] REJECTED
[ ] DEFERRED TO
[ ] REFERRED TO OTHER NAIC GROUP
[ ] EXPOSED
[ ] OTHER (SPECIFY)

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

[ x ] Health RBC Blanks  [ x ] Property/Casualty RBC Blanks  [ x ] Life and Fraternal RBC Instructions
[ x ] Health RBC Instructions  [ x ] Property/Casualty RBC Instructions  [ x ] Life and Fraternal RBC Blanks
[ ] OTHER ____________________________

DESCRIPTION OF CHANGE(S)

Incorporate references for “Incentives” under the managed care instructions and blank as “Bonuses/Incentives.”

REASON OR JUSTIFICATION FOR CHANGE **

Currently the managed care instructions and blank only reference the bonuses, this change would clarify that both incentives and bonuses are to be included.

Additional Staff Comments:

02-10-21 cgb The Proposal was exposed to the Health Risk-Based Capital (E) Working Group for a 30-day comment period that ends on Mar. 12, 2021.
03-17-21 cgb No comments were received during the comment period. The Working Group referred the proposal to the Capital Adequacy (E) Task Force for a 30-day comment period for all lines of business, with any comments to come back to the Working Group.

** This section must be completed on all forms. Revised 2-2019
The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between health entities and pure indemnity carriers. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claim payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

There are currently five levels of managed care that are used in the formula, other than for Medicare Part D Coverage, although in the future as new managed care arrangements evolve, the number of categories may increase, or new arrangements may be added to the existing categories. The managed care categories are:

- Category 0 – Arrangements not Included in Other Categories
- Category 1 – Contractual Fee Payments
- Category 2 – Bonus and/or Incentive / Withhold Arrangements
- Category 3 – Capitation
- Category 4 – Non-Contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements

For Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Lines (10) through (13) will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future, no other managed care credits are allowed for this coverage.

The managed care credit is based on the percentage of paid claims that fall into each of these categories. Total claims payments are allocated among these managed care “buckets” to determine the weighted average discount, which is then used to reduce the Underwriting Risk-Experience Fluctuation RBC. Paid claims are used instead of incurred claims due to the variability of reserves (unpaid claims) in incurred claim amounts and the difficulty in allocating reserves (unpaid claims) by managed care category.

In some instances, claim payments may fit into more than one category. If that occurs, enter the claim payments into the highest applicable category. CLAIM PAYMENTS CAN ONLY BE ENTERED INTO ONE OF THESE CATEGORIES! The total of the claim payments reported in the Managed Care Credit Calculation page should equal the total year’s paid claims.

Line (1) – Category 0 – Arrangements not Included in Other Categories. There is a zero managed care credit for claim payments in this category, which includes:

* Fee for service (charges).
* Discounted FFS (based upon charges).
* Usual Customary and Reasonable (UCR) Schedules.
* Relative Value Scales (RVS) where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less.
* Stop-loss payments by a health entity to its providers that are capitated or subject to withhold incentive programs.
* Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withhold later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement).
* Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).
This amount should equal Exhibit 7, Part 1, Column 1, Line 5 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (2) - Category 1 - Payments Made According to Contractual Arrangements. There is a 15 percent managed care credit for payments included in this category:

- Hospital per diems, DRGs or other hospital case rates.
- Non-adjustable professional case and global rates.
- Provider fee schedules.
- RVS where the payment base and RV factor are fixed by contract for more than one year.
- Ambulatory payment classifications (APCs).

This amount should equal Exhibit 7, Part 1, Column 1, Line 6 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (3) - Category 2a - Payments Made Subject to Withholds or Bonuses/Incentives With No Other Managed Care Arrangements. This category may include business that would have otherwise fit into Category 0. That is, there may be a bonus/incentives withhold arrangement with a provider who is reimbursed based on a UCR schedule (Category 0).

The maximum Category 2a managed care credit is 25 percent. The credit is based upon a calculation that determines the ratio of withholds returned and bonuses and/or incentives paid to providers during the prior year to total withholds and bonuses and incentives available to the providers during that year. That ratio is then multiplied by the average provider withhold ratio for the prior year to determine the current year’s Category 2a managed care credit factor. Bonus and/or incentive payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to the result of the following calculation:

**EXAMPLE – 2019 Reporting Year**

<table>
<thead>
<tr>
<th>Calculation</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018 withhold / bonus incentive payments</td>
<td>750,000</td>
</tr>
<tr>
<td>2018 withhold / bonuses / incentives available</td>
<td>1,000,000</td>
</tr>
<tr>
<td>A. MCC Factor Multiplier</td>
<td>75% – Eligible for credit</td>
</tr>
<tr>
<td>2018 withholds / bonuses / incentives available</td>
<td>1,000,000</td>
</tr>
<tr>
<td>2018 claims subject to withhold - gross*</td>
<td>5,000,000</td>
</tr>
<tr>
<td>B. Average Withhold Rate</td>
<td>20%</td>
</tr>
<tr>
<td>Category 2 Managed Care Credit Factor (A x B)</td>
<td>15%</td>
</tr>
</tbody>
</table>

The resulting factor is multiplied by claim payments subject to withhold - net** in the current year.

* These are amounts due before deducting withhold or paying bonuses and/or incentives.
** These are actual payments made after deducting withhold or paying bonuses and/or incentives.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives, but otherwise had no managed care arrangements.

This amount should equal Exhibit 7, Part 1, Column 1, Line 7 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).
Line (4) – Category 2b – Payments Made Subject to Withholds or Bonuses/Incentives That Are Otherwise Managed Care Category 1, Category 2b may include business that would have otherwise fit into Category 1. That is, there may be a bonus/incentive/withhold arrangement with a provider who is reimbursed based on a provider fee schedule (Category 1). The Category 2 discount for claim payments that would otherwise qualify for Category 1 is the greater of the Category 1 factor or the calculated Category 2 factor.

The maximum Category 2b managed care credit is 25 percent. The minimum of Category 2b managed care credit is 15 percent (Category 1 credit factor). The credit calculation is the same as found in the previous example for Category 2a.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives AND where the payments were made according to one of the contractual arrangements listed for Category 1. This amount should equal Exhibit 7, Part 1, Column 1, Line 8 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (5) – Category 3a – Capitated Payments Directly to Providers. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitation or percent of premium payments directly to licensed providers.

Enter the amount of claim payments paid DIRECTLY to licensed providers on a capitated basis. This amount should equal Exhibit 7, Part 1, Column 1, Line 1 + Line 3 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (6) – Category 3b – Capitated Payments to Regulated Intermediaries. There is a managed care credit of 60 percent for claim payments in this category, which includes:

- All capitation or percent of premium payments to intermediaries that in turn pay licensed providers.

Enter the amount of medical expense capitations paid to regulated intermediaries. An intermediary is a person, corporation or other business entity (not licensed as a medical provider) that arranges, by contracts with physicians and other licensed medical providers, to deliver health services for a health entity and its enrollees via a separate contract between the intermediary and the health entity. This includes affiliates of a health entity that are not subject to RBC, except in those cases where the health entity qualifies for a higher managed care credit because the capitated affiliate employs providers and pays them non-contingent salaries, and where the affiliated intermediary has a contract only with the affiliated health entity. A Regulated Intermediary is an intermediary (affiliated or not) subject to state regulation and files the Health RBC formula with the state.

Line (7) – Category 3c – Capitated Payments to Non-Regulated Intermediaries. There is a managed care credit of 60 percent for claim payments in this category, which includes:

- All capitation or percent of premium payments to intermediaries that in turn pay licensed providers. (Subject to a 5 percent limitation on payments to providers or other corporations that have no contractual relationship with such intermediary. Amounts greater than the 5 percent limitation should be reported in Category 0.)

Enter the amount of medical expense capitations paid to non-regulated intermediaries. IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under category 1 for a provider, and for an intermediary at the greater of category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive revisions
either within or beyond a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under category 0 for both providers and intermediaries.

**Line (9) – Sub-Total Paid Claims.** The total of paid claims for Comprehensive Medical, Medicare Supplement and Dental [should equal the total claims paid for the year as reported in Exhibit 7, Part 1, Line 9 + Line 10 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).]

**Line (10) – Category 0 – No Federal Reinsurance or Risk Corridor Protection.** Category 0 for Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

**Line (11) – Category 1 – Federal Reinsurance but no Risk Corridor Protection.** Category 1 for Medicare Part D Coverage would be all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

**Line (12) – Category 2a – No Federal Reinsurance but Risk Corridor Protection.** Category 2a for Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

**Line (13) – Category 3a – Federal Reinsurance and Risk Corridor Protection.** Category 3a for Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

**Line (14) – Sub-Total Paid Claims.** The total paid claims for Medicare Part D Coverage, excluding supplemental benefits.

**Line (16) – Weighted Average Managed Care Discount.** These amounts are calculated by dividing the total weighted claims by the comparable sub-total claim payments. For Column (3), this is Column (3), Line (9) divided by Column (2), Line (9). For Column (4), this is Column (4) Line (14) divided by Column (2), Line (14).
Line (17) – Weighted Average Managed Care Risk Adjustment Factor. These are the credit factors that are carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount values in Line (16).

Lines (18) through (24) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses/incentives. This table requires data from the PRIOR YEAR to compute the current year’s discount factor. These do not apply to Medicare Part D coverage.

Line (18) – Withhold & Bonus Incentive Payments, prior year. Enter the prior year’s actual withhold and bonus/incentive payments.

Line (19) – Withhold & Bonuses Incentives Available, prior year. Enter the prior year’s withhold and bonuses/incentives that were available for payment in the prior year.

Line (20) – MCC Multiplier – Average Withhold Returned. Divides Line (18) by Line (19) to determine the portion of withholds and bonuses/incentives that were actually returned in the prior year.

Line (21) – Withholds & Bonuses Incentives Available, prior year. Equal to Line (19) and is automatically pulled forward.

Line (22) – Claims Payments Subject to Withhold, prior year. Claim payments that were subject to withholds and bonuses/incentives in the prior year. Equal to L(3) + L(4) of the managed care credit claims payment table FOR THE PRIOR YEAR.

Line (23) – Average Withhold Rate, prior year. Divides Line (21) by Line (22) to determine the average withhold rate for the prior year.

Line (24) – MCC Discount Factor, Category 2. Multiplies Line (20) by Line (23) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the health entities with hold/bonus/incentive program in the prior year.
LIFE

UNDERWRITING RISK - MANAGED CARE CREDIT
LR022

This worksheet LR022 Underwriting Risk – Managed Care Credit is optional. It may be completed for only part of the comprehensive medical dental business, Stand-Alone Medicare Part D Coverage or all of them. Line (1) will be filled in as the balancing item if any of Lines (2) through (8) are entered (and then Line (9) will be required).

The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between coverages subject to the managed care credit and pure indemnity insurance. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claims payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

There are five levels of managed care that are used in the RBC formulas other than for Stand-Alone Medicare Part D Coverage, although in the future as new managed care arrangements evolve, the number of categories may increase or new arrangements may be added to the existing categories. The managed care categories are:

- Category 0 - Arrangements not Included in Other Categories
- Category 1 - Contractual Fee Payments
- Category 2 - Bonus and/or Incentives / Withhold Arrangements
- Category 3 - Capitation
- Category 4 - Non-contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements

For Stand-Alone Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Lines (10) through (13) will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future no other managed care credits are allowed for this coverage.

The managed care credit is based on the percentage of paid claims that fall into each of these categories. Total claims payments are allocated among these managed care "buckets" to determine the weighted average discount, which is then used to reduce the Underwriting Risk-Experience Fluctuation RBC. Paid claims are used instead of incurred claims due to the variability of reserves (unpaid claims) in incurred claim amounts and the difficulty in allocating reserves (unpaid claims) by managed care category.

In some instances, claims payments may fit into more than one category. If that occurs, enter the claims payments into the highest applicable category. CLAIMS PAYMENTS CAN ONLY BE ENTERED INTO ONE OF THESE CATEGORIES! The total of the claims payments reported in the managed care worksheet should equal the total year’s paid claims. Category 2a, Category 2b and Category 3c are not allowed to include non-regulated intermediaries who are affiliated with the reporting company in order to insure that true risk transfer is accomplished.

Line (1)
Category 0 - Arrangements not Included in Other Categories. There is a zero managed care credit for claim payments in this category, which includes:
- Fee for service (charges).
- Discounted fee for service (based upon charges).
• Usual customary and reasonable (UCR) schedules.
• Relative value scale (RVS), where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less.
• Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withhold later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement).
• Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).
• Claim payments not included in other categories.

**Line (2)**

Category 1 - Payments Made According to Contractual Arrangements. There is a 15 percent managed care credit for payments included in this category:

- Hospital per diems, diagnostic related groups (DRGs) or other hospital case rates.
- Non-adjustable professional case and global rates.
- Provider fee schedules.
- Relative value scale (RVS), where the payment base and RV factor are fixed by contract for more than one year.

**Line (3)**

Category 2a - Payments Made Subject to Withholds or Bonuses / Incentives with No Other Managed Care Arrangements. This category may include business that would have otherwise fit into Category 0. That is, there may be a bonus / incentives / withhold arrangement with a provider who is reimbursed based on a UCR schedule (Category 0).

The maximum Category 2a managed care credit is 25 percent. The credit is based upon a calculation that determines the ratio of withholds returned and bonuses and/or incentives paid to providers during the prior year to total withholds and bonuses and incentives available to the providers during that year. That ratio is then multiplied by the average provider withhold ratio for the prior year to determine the current year’s Category 2a managed care credit factor. Bonus and/or incentive payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to the result of the following calculation:

**EXAMPLE - 1998 Reporting Year**

<table>
<thead>
<tr>
<th>Description</th>
<th>1997 Withholds / Bonuses</th>
<th>1997 Claims Subject to Withhold - Gross†</th>
<th>Category 2 Managed Care Credit Factor (A x B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997 Withholds / Bonuses Available</td>
<td>1,000,000</td>
<td>5,000,000</td>
<td>15%</td>
</tr>
</tbody>
</table>

The resulting factor is multiplied by claims payments subject to withhold - net‡ in the current year.

† These are amounts due before deducting withhold or paying bonuses and/or incentives.
‡ These are actual payments made after deducting withhold or paying bonuses and/or incentives.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses / incentives, but otherwise had no managed care arrangements.

**Line (4)**
Category 2b - Payments Made Subject to Withholds or Bonuses / Incentives That Are Otherwise Managed Care Category 1. Category 2b may include business that would have otherwise fit into Category 1. That is, there may be a bonus / incentive / withhold arrangement with a provider who is reimbursed based on a provider fee schedule (Category 1). The Category 2 discount for claims payments that would otherwise qualify for Category 1 is the greater of the Category 1 factor or the calculated Category 2 factor.

The maximum Category 2b managed care credit is 25 percent. The minimum of Category 2b managed care credit is 15 percent (Category 1 credit factor). The credit calculation is the same as found in the previous example for Category 2a.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses / incentives AND where the payments were made according to one of the contractual arrangements listed for Category 1.

Line (5)
Category 3a - Capitated Payments Directly to Providers. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitation or percent of premium payments directly to licensed providers.

Enter the amount of claims payments paid DIRECTLY to licensed providers on a capitated basis.

Line (6)
Category 3b - Capitated Payments to Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitation or percent of premium payments to regulated intermediaries that, in turn, pay licensed providers.

Enter the amount of medical expense capitations paid to regulated intermediaries (see Appendix 2 for definition). In those cases where the capitated regulated intermediary employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

Line (7)
Category 3c - Capitated Payments to Non-Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitated or percent of premium payments to non-affiliated intermediaries that, in turn, pay licensed providers (subject to a 5 percent limitation on payments to providers or other corporations that have no contractual relationship with such intermediary. Amounts greater than the 5 percent limitation should be reported in Category 0).

Enter the amount of medical expense capitations paid to non-regulated intermediaries not affiliated with the reporting company. Do not include the amount of medical expense capitations paid to non-regulated intermediaries affiliated with the reporting company. These amounts should be reported in Category 0. Non-regulated intermediaries are those organizations that meet the definition in Appendix 2 for Intermediary but not regulated intermediary. In those cases where the capitated non-regulated intermediary (even if affiliated) employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 1 for a provider, and for an intermediary at the greater
of Category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive revisions either within or beyond a 12 month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 0 for both providers and intermediaries.

**Line (8)**
Category 4 - Medical & Hospital Expense Paid as Salary to Providers. There is a managed care credit of 75 percent for claims payments in this category. Once claims payments under this managed care category are totaled, any fee for service revenue from uninsured plans (i.e., ASO or ASC) that was included on Line (7) in the underwriting risk section should be deducted before applying the managed care credit factor.

- Non-contingent salaries to persons directly providing care.
- The portion of payments to affiliated entities passed on as non-contingent salaries to persons directly providing care where the entity has a contract only with the company.
- All facilities-related medical expenses and other non-provider medical costs generated within health facility that is owned and operated by the insurer.
- Aggregate cost payments.

Salaries paid to doctors and nurses whose sole corporate purpose is utilization review are also included in this category if such payments are classified as “medical expense” payments (paid claims) rather than administrative expenses. The Aggregate Cost method of reimbursement means where a health plan has a reimbursement plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other users of services; and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, which put their respective capital and surplus at risk in guaranteeing each other.

**Line (9)**
Subtotal Paid Claims – The total of Column (2) paid claims should equal the total claims paid for the year as reported in Schedule H, Part 5, Columns 1 and 2, Line A.4 of the annual statement.

**Line (10)**
Category 0 for Stand-Alone Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

**Line (11)**
Category 1 for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

**Line (12)**
Category 2a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

**Line (13)**
Category 3a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

**Line (16)**
Weighted Average Managed Care Discount – The amounts in Column (3) and Column (4) are calculated by dividing the total weighted claims in Column (3) by the total claims paid in Column (2) for Lines (9) and (14) respectively.

**Line (17)**
Weighted Average Managed Care Risk Adjustment Factor – These are the credit factors that are carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount (Line (16)).

Lines (18) through (24) are the calculation of the weighted average factor for the Category 2 claims payments subject to withhold and bonuses/incentives. This table requires data from the PRIOR YEAR to compute the current year’s discount factor.

**Line (18)**
Enter the prior year’s actual withhold and bonus/incentive payments.

**Line (19)**
Enter the prior year’s withhold and bonuses/incentives that were available for payment in the prior year.

**Line (20)**
Divides Line (18) by Line (19) to determine the portion of withhold and bonuses/incentives that were actually returned in the prior year.

**Line (21)**
Equal to Line (19) and is automatically pulled forward.

**Line (22)**
Claims payments that were subject to withhold and bonuses/incentives in the prior year. Equal to Line (3) + Line (4) of LR022 Underwriting Risk – Managed Care Credit FOR THE PRIOR YEAR.

**Line (23)**
Divides Line (21) by Line (22) to determine the average withhold rate for the prior year.

**Line (24)**
Multiplies Line (20) by Line (23) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the insurer’s withhold/bonus/incentive program in the prior year.
### PR021 - Underwriting Risk – Managed Care Credit

This worksheet PR021 Underwriting Risk – Managed Care Credit is optional. It may be completed for only part of the Comprehensive Medical, Stand-Alone Medicare Part D Coverage, Dental business or all of them. Line (1) will be filled in as the balancing item if any of Lines (2) through (8) are entered (and then Line (9) will be required).

The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between coverages subject to the managed care credit and pure indemnity insurance. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claims payments receive the greatest credit, while those that have less of an effect on the predictability of claims payments engender less of a discount.

There are currently five levels of managed care that are used in the RBC formulas other than for Stand-Alone Medicare Part D Coverage, although in the future as new managed care arrangements evolve, the number of categories may increase or new arrangements may be added to the existing categories. The managed care categories are:

<table>
<thead>
<tr>
<th>Category 0</th>
<th>Arrangements Not Included in Other Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1</strong></td>
<td>Contractual Fee Payments</td>
</tr>
<tr>
<td><strong>Category 2</strong></td>
<td>Bonus and/or Incentives / Withhold Arrangements</td>
</tr>
<tr>
<td><strong>Category 3</strong></td>
<td>Capitation</td>
</tr>
<tr>
<td><strong>Category 4</strong></td>
<td>Non-contingent Expenses and Aggregate Cost Arrangements</td>
</tr>
<tr>
<td><strong>Category 5</strong></td>
<td>PSA Capitated Arrangements and Certain PSA Capitated Arrangements</td>
</tr>
</tbody>
</table>

For Stand-Alone Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Lines (10.1) through (10.4) will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future no other managed care credits are allowed for this coverage.

The managed care credit is based on the percentage of paid claims that fall into each of these categories. Total claims payments are allocated among these managed care "buckets" to determine the weighted average discount, which is then used to reduce the Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental RBC. Paid claims are used instead of incurred claims due to the variability of reserves (unpaid claims) in incurred claim amounts and the difficulty in allocating reserves (unpaid claims) by managed care category.

In some instances, claims payments may fit into more than one category. If that occurs, enter the claims payments into the highest applicable category. CLAIMS PAYMENTS CAN ONLY BE ENTERED INTO ONE OF THESE CATEGORIES!

Category 0: Arrangements not included in other categories. There is zero managed care credit for claim payments in this category, which includes:

- Fee for service charges
- MIIP/OS
- Usual customary and reasonable (UCR) charges
- **Relative value scale (RVS) where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less**.
* Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withholds later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement).
* Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).
* Claim payments not included in other categories.

Line (2)
Category 1 - Payments Made According to Contractual Arrangements. There is a 15 percent managed care credit for payments included in this category:
* Hospital per diems, diagnosis related groups (DRGs) or other hospital case rates.
* Non-adjustable professional case and global rates.
* Provider fee schedules.
* Relative value scale (RVS) where the payment base and RV factor are fixed by contract for more than one year.

Line (3)
Category 2a - Payments Made Subject to Withholds or Bonuses/Incentives with No Other Managed Care Arrangements. This category may include business that would have otherwise fit into Category 0. That is, there may be a bonus/incentive withholds arrangement with a provider who is reimbursed based on a UCR schedule (Category 0).

The maximum Category 2a managed care credit is 25 percent. The credit is based upon a calculation that determines the ratio of withholds returned and bonuses and/or incentives paid to providers during the prior year to total withholds and bonuses and/or incentives available to the providers during that year. That ratio is then multiplied by the average provider withhold ratio for the prior year to determine the current year’s Category 2a managed care credit factor. Bonus and/or incentive payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to the result of the following calculation:

**EXAMPLE - 1998 Reporting Year**

<table>
<thead>
<tr>
<th>1997 withhold / bonus payments</th>
<th>$750,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997 withholds / bonuses available</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>A. MCC Factor Multiplier</td>
<td>75% - Eligible for credit</td>
</tr>
<tr>
<td>1997 withholds / bonuses available</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>1997 claims subject to withhold - gross †</td>
<td>$5,000,000</td>
</tr>
<tr>
<td>B. Average Withhold Rate</td>
<td>20%</td>
</tr>
<tr>
<td>Category 2 Managed Care Credit Factor (A x B)</td>
<td>15%</td>
</tr>
</tbody>
</table>

The resulting factor is multiplied by claims payments subject to withhold - net‡ in the current year.

† These are amounts due before deducting withhold or paying bonuses and/or incentives.
‡ These are actual payments made after deducting withhold or paying bonuses and/or incentives.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives, but otherwise had no managed care arrangements.

Line (4)
Category 2b - Payments Made Subject to Withholds or Bonuses/Incentives That Are Otherwise Managed Care Category 1. Category 2b may include business that would have otherwise fit into Category 1. That is, there may be a bonus/incentive withholds arrangement with a provider who is reimbursed based on a provider fee schedule.
(Category 1). The Category 2 discount for claims payments that would otherwise qualify for Category 1 is the greater of the Category 1 factor or the calculated Category 2 factor.

The maximum Category 2b managed care credit is 25 percent. The minimum Category 2b managed care credit is 15 percent (Category 1 credit factor). The credit calculation is the same as found in the previous example for Category 2a.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives AND where the payments were made according to one of the contractual arrangements listed for Category 1.

Line (5)
Category 3a - Capitated Payments Directly to Providers. There is a managed care credit of 60 percent for claims payments in this category, which includes:

* All capitation or percent of premium payments made directly to licensed providers.

Enter the amount of claims payments paid DIRECTLY to licensed providers on a capitated basis.

Line (6)
Category 3b - Capitated Payments to Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

* All capitation or percent of premium payments to regulated intermediaries that in turn pay licensed providers.

Enter the amount of medical expense capitations paid to regulated intermediaries (see Appendix 1 for definition). In those cases where the capitated regulated intermediary employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

Line (7)
Category 3c - Capitated Payments to Non-Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

* All capitated or percent of premium payments to non-affiliated intermediaries that in turn pay licensed providers. (Subject to a 5 percent limitation on payments to providers or other corporations that have no contractual relationship with such intermediary. Amounts greater than the 5 percent limitation should be reported in Category 0).

Enter the amount of medical expense capitations paid to non-regulated intermediaries not affiliated with the reporting company. Do not include the amount of medical expense capitations paid to non-regulated intermediaries that are affiliated with the reporting company. These amounts should be reported in Category 0. Non-regulated intermediaries are those organizations which meet the definition of Intermediary but not regulated intermediary in Appendix 1. In cases where the capitated non-regulated intermediary (even if affiliated) employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 1 for a provider, and for an intermediary at the greater of Category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive
revisions either within or beyond a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 0 for providers and intermediaries.

**Line (8)**
Category 4 - Medical & Hospital Expense Paid as Salary to Providers. There is a managed care credit of 75 percent for claims payments in this category. Once claims payments under this managed care category are totaled, any fee for service revenue from uninsured plans (i.e., ASO or ASC) that was included on Line (7) in the underwriting risk section should be deducted before applying the managed care credit factor.

* Non-contingent salaries to persons directly providing care.
* The portion of payments to affiliated entities which is passed on as non-contingent salaries to persons directly providing care where the entity has a contract only with the company.
* All facilities related medical expenses and other non-provider medical costs generated within health facility that is owned and operated by the insurer.
* Aggregate cost payments.

Salaries paid to doctors and nurses whose sole corporate purpose is utilization review are also included in this category if such payments are classified as “medical expense” payments (paid claims) rather than administrative expenses. The Aggregate Cost method of reimbursement means where a health plan has a reimbursement plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other users of services; and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, that put their respective capital and surplus at risk in guaranteeing each other.

**Line (10.1)**
Category 0 for Stand-Alone Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

**Line (10.2)**
Category 1 for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

**Line (10.3)**
Category 2a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

**Line (10.4)**
Category 3a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

**Line (10.6)**
Total Paid Claims – The total of Column (1) paid claims should equal the total claims paid for the year as reported in Schedule H, Part 5, Columns 1 and 2, Line D16 of the annual statement.

**Line (11)**
Weighted Average Managed Care Discount – This amount is calculated by dividing the total weighted claims (Line (9) Column (2)) by the total claim payments (Line (9) Column (1)).

**Line (12)**
Weighted Average Managed Care Risk Adjustment Factor - This is the credit factor that is carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount (Line (11)).

Lines (13) through (19)
Lines (13) through (19) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses incentives. This table requires data from the PRIOR YEAR to compute the current year’s discount factor.

Line (13)
Enter the prior year’s actual withhold and bonus/incentive payments.

Line (14)
Enter the prior year’s withholds and bonuses/incentives that were available for payment in the prior year.

Line (15)
Divides Line (13) by Line (14) to determine the portion of withholds and bonuses/incentives that were actually returned in the prior year.

Line (16)
Equal to Line (14) and is automatically pulled forward.

Line (17)
Claims payments that were subject to withholds and bonuses/incentives in the prior year. Equal to Line (3) + Line (4) of Underwriting Risk Managed Care Credit FOR THE PRIOR YEAR.

Line (18)
Divides Line (16) by Line (17) to determine the average withhold rate for the prior year.

Line (19)
Multiplies Line (15) by Line (18) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the insurer’s withhold/bonus incentive program in the prior year.
HEALTH, LIFE AND PROPERTY AND CASUALTY

APPENDIX 1 – COMMONLY USED TERMS

The Definitions of Commonly Used Terms are frequently duplicates from the main body of the text. If there are any inconsistencies between the definitions in this section and the definitions in the main body of the instructions, the main body definition should be used.

Incentives, Withhold and Bonus Amounts — Are amounts to be paid to providers by the Health entity as an incentive to achieve goals such as effective management of care. An incentive arrangement may involve paying an agreed-on amount for each claim (e.g., provider agrees practice in an underserved area). While a bonus arrangement may be paid at the end of a contract period after specific goals have been met. Withhold arrangements can involve a set amount to be withheld from each claim, and then paying a portion (which could be none or all) of the withheld amount at the end of the contract period.

Incentive pool, withhold, and bonus amounts are defined as: amounts to be paid to providers by the Health entity as an incentive to achieve goals such as effective management of care. Some arrangements involve paying an agreed-on amount for each claim, and then paying a bonus at the end of the contract period. Other arrangements involve a set amount to be withheld from each claim, and then paying a portion (which could be none or all) of the withheld amount at the end of the contract period.

Commented [BC1]: This could also be worded as “(e.g., provider pays on a per-claim basis for practicing in an underserved area.)”

Commented [BC2]: This is directly from the A/S instructions. It used as a basis for the definition drafted above.
## UNDERWRITING RISK - Managed Care Credit Calculation

<table>
<thead>
<tr>
<th>Managed Care Claims Payments</th>
<th>Annual Statement Source</th>
<th>(1) Paid Claims</th>
<th>(2) Weighted Claims</th>
<th>(3) Part D Managed Care Discount</th>
<th>(4) Weighted Average Managed Care Risk Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Category 0 - Arrangements not Included in Other Categories</td>
<td>Exhibit 7, Part 1, Column 1, Line 5, in part §</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Category 1 - Payments Made According to Contractual Arrangements</td>
<td>Exhibit 7, Part 1, Column 1, Line 6, in part §</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Category 2a - Subject to Withholds or Bonuses/Incentives - Otherwise Categorized</td>
<td>Exhibit 7, Part 1, Column 1, Line 7, in part §</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) Category 2b - Subject to Withholds or Bonuses/Incentives - Otherwise Categorized</td>
<td>Exhibit 7, Part 1, Column 1, Line 8, in part §</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5) Category 3a - Capitated Payments Directly to Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5.1) Capitation Payments - Medical Group - Category 3a</td>
<td>Exhibit 7, Part 1, Column 1, Line 1, in part §</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5.2) Capitation Payments - All Other Providers - Category 3a</td>
<td>Exhibit 7, Part 1, Column 1, Line 3, in part §</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6) Category 3b - Capitated Payments to Regulated Intermediaries</td>
<td>Included in Exhibit 7, Part 1, Column 1, Line 2 §</td>
<td>0.600</td>
<td>0</td>
<td>0</td>
<td>0.600</td>
</tr>
<tr>
<td>(7) Category 3c - Capitated Payments to Non-Regulated Intermediaries</td>
<td>Included in Exhibit 7, Part 1, Column 1, Line 2 §</td>
<td>0.600</td>
<td>0</td>
<td>0</td>
<td>0.600</td>
</tr>
<tr>
<td>(8) Category 4 - Medical &amp; Hospital Expense Paid as Salary to Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8.1) Non-Contingent Salaries - Category 4</td>
<td>Exhibit 7, Part 1, Column 1, Line 9, in part §</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(8.2) Aggregate Cost Arrangements - Category 4</td>
<td>Exhibit 7, Part 1, Column 1, Line 10, in part §</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8.3) Less Fee For Service Revenue from ASC or ASO</td>
<td>Company Records</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(9) Sub-Total Paid Claims</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(10) Category 0 - No Federal Reinsurance or Risk Corridor Protection</td>
<td>Company Records</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>(11) Category 1 - Federal Reinsurance but no Risk Corridor Protection</td>
<td>Company Records</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>(12) Category 2a - No Federal Reinsurance but Risk Corridor Protection</td>
<td>Company Records</td>
<td>0.667</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(13) Category 3a - Federal Reinsurance and Risk Corridor Protection Apply</td>
<td>Company Records</td>
<td>0.767</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(14) Sub-Total Paid Claims</td>
<td>Sum of Lines (10) through (13)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(15) Total Paid Claims</td>
<td>Sum of Lines (9) and (14)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Stand-Alone Medicare Part D Coverage Claim Payments

| (16) Weighted Average Managed Care Discount | | | | | |
| (17) Weighted Average Managed Care Risk Adjustment Factor | | | | | |

† This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental/Vision Managed Care Discount factor.
‡ This column is for the Medicare Part D Managed Care Discount factor.
§ Stand-Alone Medicare Part D business reported in Lines (12) and (13) would be excluded from these amounts.
* The factor is calculated on page XR018.

Denotes items that must be manually entered on filing software.
* Calculation of Category 2 Managed Care Factor

(18) Withhold & Bonus/Incentive Payments, Prior Year
(19) Withhold & Bonuses/Incentives Available, Prior Year
(20) MCC Multiplier - Average Withhold Returned [Line (18)/(19)]
(21) Withholds & Bonuses/Incentives Available, Prior Year
(22) Claims Payments Subject to Withhold, Prior Year
(23) Average Withhold Rate, Prior Year [Line (21)/(22)]
(24) MCC Discount Factor, Category 2 Min{.25,[Lines (20) x (23)]}

Annual Statement Source

(1) Amount

Company Records

Company Records
## UNDERWRITING RISK - MANAGED CARE CREDIT

### Part D

**Paid Weighted Claim Payments**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Factor</th>
<th>Annual Statement Source</th>
<th>Claims</th>
<th>Paid Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Arrangements not Included in Other Categories</td>
<td>0.000</td>
<td>Company records</td>
<td>XX</td>
<td>XXX</td>
</tr>
<tr>
<td>1</td>
<td>Payments Made According to Contractual Arrangements</td>
<td>0.150</td>
<td>Company records</td>
<td>XX</td>
<td>XX</td>
</tr>
<tr>
<td>2a</td>
<td>Subject to Withholds or Bonuses/Incentives</td>
<td>†</td>
<td>Company records</td>
<td>XX</td>
<td>0.667</td>
</tr>
<tr>
<td>2b</td>
<td>Subject to Withholds or Bonuses/Incentives</td>
<td>‡</td>
<td>Company records</td>
<td>XX</td>
<td>0.767</td>
</tr>
<tr>
<td>3a</td>
<td>Capitated Payments Directly to Providers</td>
<td>0.600</td>
<td>Company records</td>
<td>XX</td>
<td>0.600</td>
</tr>
<tr>
<td>3b</td>
<td>Capitated Payments to Regulated Intermediaries</td>
<td>0.600</td>
<td>Company records</td>
<td>XX</td>
<td>0.600</td>
</tr>
<tr>
<td>3c</td>
<td>Capitated Payments to Non-Regulated Intermediaries</td>
<td>0.600</td>
<td>Company records</td>
<td>XX</td>
<td>0.600</td>
</tr>
<tr>
<td>4</td>
<td>Medical &amp; Hospital Expense Paid as Salary to Providers</td>
<td>0.750</td>
<td>Company records</td>
<td>XX</td>
<td>XX</td>
</tr>
</tbody>
</table>

**Total Paid Claims**

| Sum of Lines (9) through (14) | Company records | XX | XX |

### Stand-Alone Medicare Part D Coverage Claim Payments

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Factor</th>
<th>Annual Statement Source</th>
<th>Claims</th>
<th>Paid Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No Federal Reinsurance or Risk Corridor Protection</td>
<td>0</td>
<td>Company records</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>1</td>
<td>Federal Reinsurance but no Risk Corridor Protection</td>
<td>0</td>
<td>Company records</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>2a</td>
<td>No Federal Reinsurance but Risk Corridor Protection</td>
<td>0.667</td>
<td>Company records</td>
<td>XX</td>
<td>0.667</td>
</tr>
<tr>
<td>3a</td>
<td>Federal Reinsurance and Risk Corridor Protection apply</td>
<td>0.767</td>
<td>Company records</td>
<td>XX</td>
<td>0.767</td>
</tr>
</tbody>
</table>

### Managed Care Credit Multiplier – Average Withhold Returned

| Line (18) / Line (19) | Line (21) / Line (22) | Line (20) x Line (23) |

**Managed Care Credit Discount Factor, Category 2**

| Minimum of 0.25 or Line (24) | Line (25) |

Notes:
- Denotes items that must be manually entered on the filing software.
- This column is for the Comprehensive Medical & Hospital, Medicare Supplement and Dental Managed Care discount factor.
## UNDERWRITING RISK - MANAGED CARE CREDIT  PR021

### Comprehensive Medical, Medicare Supplement and Dental & Vision Claim Payments

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Annual Statement Source</th>
<th>Paid Claims</th>
<th>Factor</th>
<th>Weighted Claim*</th>
<th>Weighted Claim†</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>Category 0 - Arrangements not Included in Other Categories</td>
<td>Company records</td>
<td>0</td>
<td>0.000</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>Category 1 - Payments Made According to Contractual Arrangements</td>
<td>Company records</td>
<td>0</td>
<td>0.150</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(3)</td>
<td>Category 2a - Subject to Withholds or Bonuses/Incentives - Otherwise Category 0</td>
<td>Company records</td>
<td>0</td>
<td>*</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(4)</td>
<td>Category 2b - Subject to Withholds or Bonuses/Incentives - Otherwise Category 1</td>
<td>Company records</td>
<td>0</td>
<td>**</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(5)</td>
<td>Category 3a - Capitated Payments Directly to Providers</td>
<td>Company records</td>
<td>0</td>
<td>0.600</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(6)</td>
<td>Category 3b - Capitated Payments to Regulated Intermediaries</td>
<td>Company records</td>
<td>0</td>
<td>0.600</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(7)</td>
<td>Category 3c - Capitated Payments to Non-Regulated Intermediaries</td>
<td>Company records</td>
<td>0</td>
<td>0.600</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(8)</td>
<td>Category 4 - Medical &amp; Hospital Expense Paid as Salary to Providers</td>
<td>Company records</td>
<td>0</td>
<td>0.750</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(9)</td>
<td>Sub-Total Paid Claims</td>
<td>Sum of Lines (1) through (8)</td>
<td>0</td>
<td>0</td>
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<td></td>
</tr>
</tbody>
</table>

### Stand-Alone Medicare Part D Coverage Claim Payments

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Annual Statement Source</th>
<th>Paid Claims</th>
<th>Factor</th>
<th>Weighted Claim*</th>
<th>Weighted Claim†</th>
</tr>
</thead>
<tbody>
<tr>
<td>(10.1)</td>
<td>Category 0 - No Federal Reinsurance or Risk Corridor Protection</td>
<td>Company records</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>(10.2)</td>
<td>Category 1 - Federal Reinsurance but no Risk Corridor Protection</td>
<td>Company records</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(10.3)</td>
<td>Category 3a - Federal Reinsurance and Risk Corridor Protection apply</td>
<td>Company records</td>
<td>0</td>
<td>0.667</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(10.4)</td>
<td>Category 3b - Federal Reinsurance and Risk Corridor Protection apply</td>
<td>Company records</td>
<td>0</td>
<td>0.667</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(10.5)</td>
<td>Sub-Total Paid Claims</td>
<td>Sum of Lines (10.1) through (10.4)</td>
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<td></td>
</tr>
<tr>
<td>(10.6)</td>
<td>Total Paid Claims</td>
<td>Sum of Lines (9) and (10.5)</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(11)</td>
<td>Weighted Average Managed Care Discount</td>
<td>Col (1) = Col (3) Line (9) / Col (2) Line (9)</td>
<td>0.000</td>
<td>0.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(12)</td>
<td>Weighted Average Managed Care Risk Adjustment Factor</td>
<td>Col (1) = 1.0 × Col (3) Line (11)</td>
<td>0.000</td>
<td>0.000</td>
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<td></td>
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</table>

### Calculation of Category 2 Managed Care Factor

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>(13)</td>
<td>Withhold &amp; bonus/Incentive payments, prior year</td>
<td>0.000</td>
</tr>
<tr>
<td>(14)</td>
<td>Withhold &amp; bonuses/Incentives available, prior year</td>
<td>0.000</td>
</tr>
<tr>
<td>(15)</td>
<td>Managed Care Credit Multiplier – average withhold returned</td>
<td>0.000</td>
</tr>
<tr>
<td>(16)</td>
<td>Claims payments subject to withhold, prior year</td>
<td>0.000</td>
</tr>
<tr>
<td>(17)</td>
<td>Average withhold rate, prior year</td>
<td>0.000</td>
</tr>
<tr>
<td>(18)</td>
<td>Managed Care Credit Discount Factor, Category 2</td>
<td>0.000</td>
</tr>
</tbody>
</table>

* Category 2 Managed Care Factor calculated on Line (19)
**Category 2 Managed Care Factor calculated on Line (19) with a minimum factor of 15 percent.
†† This column is for the Stand-Alone Medicare Part D managed care discount factor.

Denotes items that must be manually entered on the filing software.
Add instructions to PR027 Interrogatories that clarify how insurers with no gross exposure to earthquake or hurricane should complete the Interrogatories.

**REASON OR JUSTIFICATION FOR CHANGE**

Some insurers with no earthquake and/or hurricane exposure did not file PR027A, PR027B and the Interrogatories on PR027. This results with situation that it is not clear if the insurers fail to complete the exhibits or they simply have no gross exposure, thus creating cross-check problem. The clarification wording will reduce the cross-check problems experienced by NAIC.

**Additional Staff Comments:**

10/19/20 – The Cat Risk SG exposed the proposal for a thirty-day public comment period ending Nov. 18.
03/08/21 – The Cat Risk SG adopted the proposal.
03/15/21 – The P/C RBC WG adopted the proposal.

**This section must be completed on all forms.**

Revised 2-2019
CALCULATION OF CATASTROPHE RISK CHARGE RCAT
PR027

The catastrophe risk charge for earthquake (PR027A) and hurricane (PR027B) risks is calculated by multiplying the RBC factors by the corresponding modeled losses and reinsurance recoverables. The risk applies on a net basis with a corresponding contingent credit risk charge for certain categories of reinsurers. Data must be provided for the worst year in 50, 100, 250, and 500; however, only the worst year in 100 will be used in the calculation of the catastrophe risk charge. While projected losses modeled on an Aggregate Exceedance Probability basis is preferred, companies are permitted to report on an Occurrence Exceedance Probability basis if that is consistent with the company’s internal risk management process.

The Grand Total (PR027) page includes an interrogatory to support an exemption from filing the catastrophe risk charge. Any company qualifying for exemption from the earthquake risk charge must identify the particular criteria from among (1a), (1b), (2) and (3) that provides its qualification for exemption, and may leave the other three items from this group of four possible qualifications for exemption blank; except identification of criteria (3) as the basis for the exemption requires a further answer to (3a) and (3b). If an insurer does not write or assume earthquake risks leaving no gross exposure, enter an “X” in interrogatory 3, with no need to fill in (3a) and (3b). Any company qualifying for exemption from the hurricane risk charge must identify the particular criteria from among (4a), (4b), (5) and (6) that provides its qualification for exemption, and may leave the other three items from this second group of four possible qualifications for exemption blank. If an insurer does not write or assume hurricane risks leaving no gross exposure, enter an “X” in interrogatory 6.

If the company qualifies for exemption from the earthquake risk charge, page PR027A and line (1) on this page may be left blank. If the company qualifies for exemption from the hurricane risk charge, page PR027B and line (2) on this page may be left blank.

In general, the following conditions will qualify a company for exemption: if it uses an intercompany pooling arrangement or quota share arrangement with U.S. affiliates covering 100% of its earthquake and hurricane risks such that there is no exposure for these risks; if it has a ratio of Insured Value – Property to surplus as regards policyholders of less than 50%; or if it writes Insured Value – Property that includes hurricane and/or earthquake coverage in catastrophe-prone areas representing less than 10% of its surplus as regards policyholders.

“Insured Value – Property” includes aggregate policy limits for structures and contents for policies written and assumed in the following annual statement lines – Fire, Allied Lines, Earthquake, Farmowners, Homeowners, and Commercial Multi-Peril.

“This group of possible qualifications for exemption: if it uses an intercompany pooling arrangement or quota share arrangement with U.S. affiliates covering 100% of its earthquake and hurricane risks such that there is no exposure for these risks; if it has a ratio of Insured Value – Property to surplus as regards policyholders of less than 50%; or if it writes Insured Value – Property that includes hurricane and/or earthquake coverage in catastrophe-prone areas representing less than 10% of its surplus as regards policyholders.

“Catastrophe-Prone Areas in the U.S.” include:

i. For hurricane risks, Hawaii, District of Columbia and states and commonwealths bordering on the Atlantic Ocean and/or the Gulf of Mexico including Puerto Rico.

ii. For earthquake risk or for fire following earthquake, any of the following commonwealth or states: Alaska, Hawaii, Washington, Oregon, California, Idaho, Nevada, Utah, Arizona, Montana, Wyoming, Colorado, New Mexico, Puerto Rico, and geographic areas in the following states that are in the New Madrid Seismic Zone - Missouri, Arkansas, Mississippi, Tennessee, Illinois and Kentucky.
The proposed change would remove the embedded 3% operational risk component contained in the reinsurance contingent credit risk factor of $R_{cat}$.

**REASON OR JUSTIFICATION FOR CHANGE **

Operational risk is now separately addressed in RBC as a stand-alone capital add-on. When this factor was implemented, it borrowed from the credit risk factors in R3 that included a load for operational risk. This is assessment of operational risk is duplicative and is inadvertently being applied in $R_{cat}$. The gross modeled $R_{cat}$ risk does not apply this duplicative assessment of operational risk to $R_{cat}$, and it follows that it should not be applied to ceded modeled $R_{cat}$ risk either.

**Additional Staff Comments:**

10/27/20 – The PCRBC WG exposed this proposal for a 35-day public comment period ending Dec. 1.
03/08/21 – The Cat Risk SG adopted the proposal.
03/15/21 – The P/C RBC WG adopted the proposal.

**This section must be completed on all forms.**
Specific Instructions for Application of the Formula

**Column (1) – Direct and Assumed Modeled Losses**
These are the direct and assumed modeled losses per the first footnote. Include losses only; no loss adjustment expenses. For companies that are part of an inter-company pooling arrangement, the losses in this column should be consistent with those reported in Schedule P, i.e. losses reported in this column should be the gross losses for the pool multiplied by the company’s share of the pool.

**Column (2) – Net Modeled Losses**
These are the net modeled losses per the footnote. Include losses only; no loss adjustment expenses.

**Column (3) – Ceded Amounts Recoverable**
These are the modeled losses ceded under any reinsurance contract. Include losses only, no loss adjustment expenses, and should be associated with the Net Modeled Losses.

**Column (4) – Ceded Amounts with Zero Credit Risk Charge**
Per the footnote, modeled catastrophe losses that would be ceded to the categories of reinsurers that are not subject to the RBC credit risk charge (i.e., U.S. affiliates and mandatory pools, whether authorized, unauthorized, or certified).

**Column (5) – Amount**
These are automatically calculated based on the previous columns.

**Column (6) – RBC Requirement**
A factor of 1.000 is applied to the reported modeled catastrophe losses calculated on both AEP and OEP basis, and a factor of **0.018** is applied to the reinsurance recoverables. The RBC Requirement is based on either AEP reported results or OEP reported results (not both), consistent with the way the company internally evaluates and manages its modeled net catastrophe risk.

**Column (5) – Y/N**
Please indicate “Y” for OEP basis and “N” for AEP basis. This column should not be blank.
### CALCULATION OF CATASTROPHE RISK CHARGE FOR EARTHQUAKE  PR027A

<table>
<thead>
<tr>
<th>Earthquake Reference</th>
<th>Direct and Assumed</th>
<th>Net</th>
<th>Ceded Amounts Recoverable</th>
<th>Ceded Amounts Recoverable with zero Credit Risk Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Worst Year in 50</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Worst Year in 100</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Worst Year in 250</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) Worst Year in 500</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reference</th>
<th>Amount</th>
<th>Factor</th>
<th>RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(6) Net Earthquake Risk</td>
<td>1(C(2))</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(7) Contingent Credit Risk for Earthquake Risk</td>
<td>L(2) C(3) - C(4)</td>
<td>0.018</td>
<td>0</td>
</tr>
<tr>
<td>(8) Total Earthquake Catastrophe Risk (OEP Basis)</td>
<td>L(2) C(3) - C(4)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(9) Total Earthquake Catastrophe Risk (OEP Basis)</td>
<td>If L(5) C(5) = &quot;N&quot;, L(6) C(6) = L(6) C(7)- L(7) C(7), otherwise &quot;0&quot;</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(10) Total Earthquake Catastrophe Risk</td>
<td>L(2) C(3) - L(9) C(7)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

† Has the company reported above, its modeled earthquake losses using an occurrence exceedance probability (OEP) basis?

†† Column (4) is modeled catastrophe losses that would be ceded to the categories of reinsurers that are not subject to the RBC credit risk charge (i.e., U.S. affiliates and mandatory pools, whether authorized, unauthorized, or certified).

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

---

Lines (1)-(4): Modeled losses to be entered on these lines are to be calculated using one of the following NAIC approved third party commercial vendor catastrophe models - AIR, EQECAT, RMS, the ARA HurLoss Model, or the Florida Public Model for hurricanes or a catastrophe model that is internally developed by the insurer and has received permission of use by the lead or domestic state. The insurance company’s own insured property exposure information should be used as inputs to the model(s). The insurance company may elect to use the modeled results from any one of the models, or any combination of the results of two or more of the models. Each insurer will not be required to utilize any prescribed set of modeling assumptions, but will be expected to use the same data, modeling, and assumptions that the insurer uses in its own internal catastrophe risk management process. An attestation to this effect and an explanation of the company’s key assumptions and model selection may be required, and the company’s catastrophe data, assumptions, model and results may be subject to examination.

† Column (3) is modeled catastrophe losses that would be ceded under reinsurance contracts. This should be associated with the Net Modeled Losses shown in Column (2).

†† Column (4) is modeled catastrophe losses that would be ceded to the categories of reinsurers that are not subject to the RBC credit risk charge (i.e., U.S. affiliates and mandatory pools, whether authorized, unauthorized, or certified).
### CALCULATION OF CATASTROPHE RISK CHARGE FOR HURRICANE PR027B

<table>
<thead>
<tr>
<th>Hurricane Reference</th>
<th>Reference</th>
<th>(1) Direct and Assumed</th>
<th>(2) Net</th>
<th>Ceded Amounts Recoverable</th>
<th>Ceded Amounts Recoverable with zero Credit Risk Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Worst Year in 50</td>
<td>Company Records</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>(2) Worst Year in 100</td>
<td>Company Records</td>
<td></td>
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<tr>
<td>(3) Worst Year in 250</td>
<td>Company Records</td>
<td></td>
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<tr>
<td>(4) Worst Year in 500</td>
<td>Company Records</td>
<td></td>
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</tbody>
</table>

† Column (4) is modeled catastrophe losses that would be ceded to the categories of reinsurers that are not subject to the RBC credit risk charge (i.e., U.S. affiliates and mandatory pools, whether authorized, unauthorized, or certified).

†† Column (3) is modeled catastrophe losses that would be ceded under reinsurance contracts. This should be associated with the Net Modeled Losses shown in Column (2).

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

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5/23/21

Attachment Nine

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NAIC Proceedings – Spring 2021
### CAPITAL ADEQUACY (E) TASK FORCE

**WORKING AGENDA ITEMS FOR CALENDAR YEAR 2020**

<table>
<thead>
<tr>
<th>#</th>
<th>Owner</th>
<th>Priority</th>
<th>Expected Completion Date</th>
<th>Working Agenda Item</th>
<th>Source</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2020 #</strong></td>
<td><strong>2020 Priority</strong></td>
<td><strong>Expected Completion Date</strong></td>
<td><strong>Working Agenda Item</strong></td>
<td><strong>Source</strong></td>
<td><strong>Comments</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing Items – Life RBC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Life RBC WG</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>Make technical corrections to Life RBC instructions, blank and/or methods to provide for consistent treatment among asset types and among the various components of the RBC calculations for a single asset type.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021 or later</td>
<td>1. Monitor the impact of the changes to the variable annuities reserve framework and risk-based capital (RBC) calculation and determine if additional revisions need to be made. 2. Develop and recommend appropriate changes including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.</td>
<td>CATF</td>
<td>Being addressed by the Variable Annuities Capital and Reserve (E/A) Subgroup</td>
</tr>
<tr>
<td>3</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021 or later</td>
<td>Provide recommendations for recognizing longevity risk in statutory reserves and/or RBC, as appropriate.</td>
<td>New Jersey</td>
<td>Being addressed by the Longevity (E/A) Subgroup</td>
</tr>
<tr>
<td><strong>Carry-Over Items Currently Being Addressed – Life RBC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021 or later</td>
<td>Update the current C-3 Phase I or C-3 Phase II methodology to include indexed annuities with consideration of contingent deferred annuities as well.</td>
<td>AAA</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021</td>
<td>Determine if any adjustment is needed to the XXX/AXXX RBC Shortfall calculation to address surplus notes issued by captives.</td>
<td>11/1/17 Referral from the Reinsurance (E) Task Force</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021</td>
<td>Determine if any adjustment is needed due to the changes made to the Life and Health Guaranty Association Model Act, Model #520.</td>
<td>9/1/2018</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021</td>
<td>Determine if any adjustment is needed to the reinsurance credit risk in light of changes related to collateral and the changes made to the property RBC formula.</td>
<td>9/1/2018</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021</td>
<td>Discuss and determine the bond factors for the 20 designations.</td>
<td>Referral from Investment RBC July/2020</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021</td>
<td>Discuss and determine the need to adjust the real estate factors.</td>
<td>Referral from Investment RBC July/2020</td>
<td></td>
</tr>
<tr>
<td><strong>New Items – Life</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021 or later</td>
<td>Work with the Life Actuarial (E) Task Force and Conning to develop the economic scenario generator for implementation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Carry-Over Items Currently Being Addressed – P&amp;C RBC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Cat Risk SG</td>
<td>1</td>
<td>Year-end 2022 or later</td>
<td>Continue development of RBC formula revisions to include a risk charge based on catastrophe model output: a) Evaluate other catastrophe risks for possible inclusion in the charge - determine whether to recommend developing charges for any additional perils, and which perils or perils those should be.</td>
<td>The SG agreed on adding Wildfire Peril to Rcat.</td>
<td>10/19/2020</td>
</tr>
<tr>
<td>Priority</td>
<td>Owner</td>
<td>Priority</td>
<td>Working Agenda Item</td>
<td>#</td>
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<td>Priority Date</td>
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<tr>
<td>1</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>Year-end 2020 or later</td>
<td>2020</td>
<td>Summer Meeting or later</td>
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<tr>
<td>2</td>
<td>RBC WG</td>
<td>2</td>
<td>2021</td>
<td>Summer Meeting or later</td>
<td>2021</td>
<td>Evaluate the proposed changes from the Affiliated Investment Ad Hoc Group related to P/C RBC Affiliated Investments.</td>
</tr>
<tr>
<td>3</td>
<td>P&amp;C RBC WG</td>
<td>3</td>
<td>Year-end 2020 or later</td>
<td>2020</td>
<td>Summer Meeting or later</td>
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<tr>
<td>4</td>
<td>P&amp;C RBC VG</td>
<td>4</td>
<td>Year-end 2021 or later</td>
<td>2021</td>
<td>Summer Meeting or later</td>
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<td>5</td>
<td>RBC WG</td>
<td>5</td>
<td>Year-end 2021 or later</td>
<td>2021</td>
<td>Summer Meeting or later</td>
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</tr>
<tr>
<td>6</td>
<td>Cat Risk</td>
<td>6</td>
<td>Year-end 2020 or later</td>
<td>2020</td>
<td>Summer Meeting or later</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>Cat Risk</td>
<td>7</td>
<td>Year-end 2021 or later</td>
<td>2021</td>
<td>Summer Meeting or later</td>
<td>7</td>
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<td>8</td>
<td>P&amp;C RBC WG</td>
<td>8</td>
<td>Year-end 2020 or later</td>
<td>2020</td>
<td>Summer Meeting or later</td>
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<tr>
<td>9</td>
<td>Cat Risk</td>
<td>9</td>
<td>Year-end 2021 or later</td>
<td>2021</td>
<td>Summer Meeting or later</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>P&amp;C RBC WG</td>
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<td>2020</td>
<td>Summer Meeting or later</td>
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<tr>
<td>11</td>
<td>P&amp;C RBC WG</td>
<td>11</td>
<td>Year-end 2020 or later</td>
<td>2020</td>
<td>Summer Meeting or later</td>
<td>11</td>
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</table>
# Capital Adequacy (E) Task Force

## Working Agenda Items for Calendar Year 2020

### New Items – P&C RBC

<table>
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<tr>
<th>2020 #</th>
<th>Owner</th>
<th>2020 Priority</th>
<th>Expected Completion Date</th>
<th>Working Agenda Item</th>
<th>Source</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>12</td>
<td>Cat Risk SG</td>
<td>1</td>
<td>2022 Spring Meeting or later</td>
<td>Implement Wildfire Peril in the Rcat component (For Informational Purpose Only)</td>
<td></td>
<td>3/8/2021</td>
</tr>
</tbody>
</table>

### Ongoing Items – Health RBC

<table>
<thead>
<tr>
<th>2020 #</th>
<th>Owner</th>
<th>2020 Priority</th>
<th>Expected Completion Date</th>
<th>Working Agenda Item</th>
<th>Source</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Health RBC WG</td>
<td>2</td>
<td>Year-end 2022 RBC or later</td>
<td>Discuss and monitor the development of federal level programs and actions and the potential impact of these changes to the HRBC formula: - Development of the state reinsurance programs; - Association Health Plans; - Cross-border sales</td>
<td>HRBCWG</td>
<td>1/11/2018</td>
</tr>
</tbody>
</table>

### Carry-Over Items Currently being Addressed – Health RBC

<table>
<thead>
<tr>
<th>2020 #</th>
<th>Owner</th>
<th>2020 Priority</th>
<th>Expected Completion Date</th>
<th>Working Agenda Item</th>
<th>Source</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Health RBC WG</td>
<td>3</td>
<td>Year-End 2023 RBC or Later</td>
<td>Consider changes for stop-loss insurance or reinsurance.</td>
<td>AAA Report at Dec. 2006 Meeting (Based on Academy report expected to be received at YE-2016)</td>
<td>2016-17-CA</td>
</tr>
<tr>
<td>4</td>
<td>Health RBC WG</td>
<td>2</td>
<td>Year-end 2023 RBC or later</td>
<td>Review the individual factors for each health care receivables line within the Credit Risk H3 component of the RBC formula.</td>
<td>HRBC WG</td>
<td>Adopted 2016-06-H, Rejected 2019-04-H, Annual Statement Guidance (Year-End 2020) and Annual Statement Blanks Proposal (Year-End 2021) referred to the Blanks (E) Working Group</td>
</tr>
<tr>
<td>2020 #</td>
<td>Owner</td>
<td>2020 Priority</td>
<td>Expected Completion Date</td>
<td>Working Agenda Item</td>
<td>Source</td>
<td>Comments</td>
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<td>------------------------------------------------------------------------------------</td>
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<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5</td>
<td>Health RBC WG</td>
<td>1</td>
<td>Year-end 2022 or later</td>
<td>Establish an Ad Hoc Group to review the Health Test and annual statement changes for reporting health business in the Life and P/C Blanks</td>
<td>HRBCWG</td>
<td>Evaluate the applicability of the current Health Test in the Annual Statement instructions in today's health insurance market. Discuss ways to gather additional information for health business reported in other blanks.</td>
</tr>
<tr>
<td>6</td>
<td>Health RBC WG</td>
<td>1</td>
<td>Year-end 20220 RBC or later</td>
<td>Review the Managed Care Credit calculation in the Health RBC formula - specifically Category 2a and 2b. Review Managed Care Credit across formulas.</td>
<td>HRBCWG</td>
<td>Review the Managed Care Category and the credit calculated, more specifically the credit calculated when moving from Category 0 &amp; 1 to 2a and 2b.</td>
</tr>
<tr>
<td>7</td>
<td>Health RBC WG</td>
<td>1</td>
<td>Year-end 20220 or later</td>
<td>Review referral letter from the Operational Risk (E) Subgroup on the excessive growth charge and the development of an Ad Hoc group to charge.</td>
<td>HRBCWG</td>
<td>Review if changes are required to the Health RBC Formula</td>
</tr>
<tr>
<td>8</td>
<td>Health RBC WG</td>
<td>1</td>
<td>2021 Spring Meeting</td>
<td>Review and consider the formula for the MAX function in Line 17 of the Excessive Growth Charge.</td>
<td>HRBCWG</td>
<td>Adopted 2020-01-H</td>
</tr>
<tr>
<td>9</td>
<td>Health RBC WG</td>
<td>1</td>
<td>Year-End 202204 or later</td>
<td>Consider impact of COVID-19 and pandemic risk in the Health RBC formula.</td>
<td>HRBCWG</td>
<td>Referral Letter was sent to the Academy on Sept 21.</td>
</tr>
<tr>
<td>10</td>
<td>Health RBC WG</td>
<td>1</td>
<td>Year-End 2021 or later</td>
<td>Work with the Academy to evaluate incorporating and including investment income in the Underwriting Risk component of the Health RBC formula.</td>
<td>HRBCWG</td>
<td>Referral Letter was sent to the Academy on Sept 21.</td>
</tr>
<tr>
<td>11</td>
<td>Health RBC WG</td>
<td>1</td>
<td>2021</td>
<td>Discuss and determine the bond factors for the 20 designations. Referral from Investment RBC July 2020</td>
<td>Referral from Investment RBC July 2020</td>
<td>Working Group will use two- and five-year time horizon factors in 2020 impact analysis.</td>
</tr>
</tbody>
</table>

**New Items – Health RBC**

| 12     | CADTF      | 1              | 2021 or Later | Supplementary Investment Risks Interrogatories (SIRI) | Referral from Blackrock and IL DOI | The Task Force received the referral on Oct. 27. This referral will be tabled until the bond factors have been adopted and the TF will conduct a holistic review all investment referrals. | 11/19/2020          |

**Ongoing Items – Task Force**
# Capital Adequacy (E) Task Force

## Working Agenda Items for Calendar Year 2020

**Priority 1 – High priority**

**Priority 2 – Medium priority**

**Priority 3 – Low priority**

<table>
<thead>
<tr>
<th>#</th>
<th>Owner</th>
<th>2020 Priority</th>
<th>Expected Completion Date</th>
<th>Working Agenda Item</th>
<th>Source</th>
<th>Comments</th>
<th>Date Added to Agenda</th>
</tr>
</thead>
</table>
| 13 | CADTF | 1 2020 | Consideration given to 20 designations for bonds in all RBC formulas so that an impact analysis can be provided on 2020 year-end data to determine the bond RBC factors. The Task Force will need to discuss and determine whether Hybrids are included with the new bond's structure. 

**History**

In 2012/13 as part of the Solvency Modernization Initiative “roadmap” and subsequent White Paper roadmap, the Capital Adequacy (E) Task Force identified increased granularity in the asset and investment risk charges as a priority area. It was originally targeted at the Life RBC formula and was referred to as the “C1 factor review”. The project was assigned to a newly formed Investment RBC (E) Working Group in 2013. Work was conducted by the Life C-1 Work Group of American Academy of Actuaries (Academy) at the instructions of the working group using defined criteria for the analysis. The C1 bond factors are defined as the amount needed to pre-fund losses at the 96th percentile minus the amount assumed to be funded in statutory policy reserves. The credit loss distribution is skewed with the mean occurring at approximately the 60th percentile. The RP does not vary by economic scenario. | RBCWG - Dec 2019 | An Academy report issued in 2015 and updated 2017 report recommended an increase in the number of designations. Ultimately, the WG members agreed that the number of designations should be increased to 20. 

In 2017/2018, the PRBC and HRBC (E) Working Groups began discussion of the change to 20 designations. In 2019 both working groups concurred with the LRBC WG position that the number of designations should be increased to 19 in their respective formulas Proposal # 2019 – 16CA | |
| 14 | CADTF | 2 2022 | Affiliated Investment Subsidiaries Referral Ad Hoc group formed Sept. 2016 | Ad Hoc Group | Ad Hoc group will provide periodic updates on their progress. | |
| 15 | CADTF | 3 2021 | Receivable for Securities factor | Consider evaluating the factor every 3 years. (2021, 2024, 2027, etc.) | |
| 16 | CADTF | 3 2021 or Later | NAIC Designation for Schedule D, Part 2 Section 2 - Common Stocks

**Equity investments that have an underlying bond characteristic should have a lower RBC charge? Similar to existing guidance for SVO-identified ETFs reported on Schedule D-1, are treated as bonds.** | Referral from SAPWG 8/13/2018 | 10/8/19 - Exposed for a 30-day Comment period ending 11/8/2019 3-22-20 - Tabled discussion pending adoption of the bond structure and factors. | 10/11/2018 |
| 17 | CADTF | 3 2021 or Later | Structured Notes - defined as an investment that is structured to resemble a debt instrument, where the contractual amount of the instrument to be paid at maturity is at risk for other than the failure of the borrower to pay the contractual amount due. Structured notes reflect derivative instruments (i.e. put option or forward contract) that are wrapped by a debt structure. | Referral from SAPWG April 16, 2019 | 10/8/19 - Exposed for a 30-day Comment period ending 11/8/2019 3-22-20 - Tabled discussion pending adoption of the bond structure and factors. | 8/4/2019 |
| 18 | CADTF | 3 2021 or Later | Comprehensive Fund Review for investments reported on Schedule D Pt 2 Sn2 | Referral from VOSTF 9/21/2018 | Discussed during Spring Mtg. NAIC staff to do analysis. 10/8/19 - Exposed for a 30-day comment period ending 11/8/19 3-22-20 - Tabled discussion pending adoption of the bond structure and | 11/16/2018 |
## Capital Adequacy (E) Task Force

**Working Agenda Items for Calendar Year 2020**

<table>
<thead>
<tr>
<th>2020 #</th>
<th>Owner</th>
<th>Priority</th>
<th>Expected Completion Date</th>
<th>Working Agenda Item</th>
<th>Source</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>CADTF</td>
<td>2</td>
<td>2020 or Later</td>
<td>XXX/AXXX Captive Reinsurance RBC Shortfall</td>
<td>Referral from Reinsurance Task Force /RITF</td>
<td>Referred to Life RBC WG for consideration and comment</td>
</tr>
<tr>
<td>20</td>
<td>CADTF</td>
<td>2</td>
<td>2020 or Later</td>
<td>Payout Annuities for RBC</td>
<td>Referral from Allstate and IL DOI</td>
<td>Referred to Life RBC WG for consideration and comment</td>
</tr>
<tr>
<td>21</td>
<td>CADTF</td>
<td>2</td>
<td>2020 or Later</td>
<td>Guaranty Association Assessment Risk</td>
<td>Referral from Receivership and Insolvency (E) Task Force</td>
<td>Referred to the Life RBC WG and Health RBC WG for consideration and comment</td>
</tr>
</tbody>
</table>

**Carry-Over Items Currently being Addressed – Task Force**

- XXX/AXXX Captive Reinsurance RBC Shortfall
- Payout Annuities for RBC
- Guaranty Association Assessment Risk

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EXAMINATION OVERSIGHT (E) TASK FORCE

Examination Oversight (E) Task Force March 25, 2021, Minutes .........................................................................................................................10-847
The Examination Oversight (E) Task Force met March 25, 2021. The following Task Force members participated: Judith L. French, Chair, represented by Dwight Radel (OH); Carter Lawrence, Vice Chair, represented by Joy Little (TN); Lori K. Wing-Heier represented by David Phifer (AK); Alan McClain represented by Mel Anderson (AR); Jon Savary represented by David Lee (AZ); Ricardo Lara represented by Susan Bernard (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by William Arfanis (CT); Karima M. Woods represented by N. Kevin Brown (DC); Doug Ommen represented by Daniel Mathis (IA); Dean L. Cameron represented by Eric Fletcher (ID); Stephen W. Robertson represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Jeff Gaither (KY); James J. Donelon represented by Melissa Gibson (LA); Gary D. Anderson represented by James A. McCarthy (MA); Anita G. Fox represented by Judy Weaver (MI); Grace Arnold represented by Kathleen Orth (MN); Chlora Lindley-Myers represented by Shannon Schmoeger (MO); Jon Godfread represented by Matt Fischer (ND); Bruce R. Ramge represented by Justin Schrader (NE); Chris Nicolopoulos represented by Patricia Gosselin (NH); Russell Toal represented by Beatrice Geickler (NM); Glen Mulready represented by Eli Snowbarger (OK); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Larry D. Deiter represented by Johanna Nickelson (SD); Doug Slape represented by Shawn Frederick (TX); Jonathan T. Pike represented by Malis Rasmussen (UT); Scott A. White represented by David Smith and Doug Stolte (VA); Mark Afable represented by Amy Malm (WI); and Jeff Rude represented by Linda Johnson (WY).

1. **Adopted its Nov. 17, 2020, Minutes**

Ms. Malm made a motion, seconded by Mr. Kaumann, to adopt the Task Force’s Nov. 17, 2020, minutes (see NAIC Proceedings – Fall 2020, Examination Oversight (E) Task Force). The motion passed unanimously.

2. **Adopted the Reports of its Working Groups**

   a. **Electronic Workpaper (E) Working Group**

Ms. Bernard provided the report of the Electronic Workpaper (E) Working Group. She stated that the Working Group met March 15 and Jan. 27 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings, to continue discussions on evaluating replacement options for TeamMate AM, which will be reaching its end of life in 2023.

   b. **Financial Examiners Coordination (E) Working Group**

Mr. Arfanis provided the report of the Financial Examiners Coordination (E) Working Group. He stated that the Working Group met March 18 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to receive reports on exam coordination efforts from selected states.


Having no further business, the Examination Oversight (E) Task Force adjourned into regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to receive reports on exams open past 22 months.
FINANCIAL STABILITY (E) TASK FORCE

Liquidity Assessment (E) Subgroup 2021 Membership and Charges (Attachment One) ......................... 10-851
Receivership and Insolvency (E) Task Force Report (Attachment Two) ............................................... 10-852
Insurance Holding Company System Regulatory Act (#440) Accreditation Recommendations to the Financial Condition (E) Committee (Attachment Three) ................................................................. 10-855
The Financial Stability (E) Task Force met Feb. 22, 2021. The following Task Force members participated: Marlene Caride, Chair (NJ); Eric A. Cioppa, Vice Chair (ME); Alan McClain represented by Mel Anderson (AR); Ricardo Lara represented by Susan Bernard (CA); Andrew N. Mais represented by Kathy Belfi (CT); Karima M. Woods represented by Philip Barlow (DC); David Altmaier represented by Ray Spudeck (FL); Doug Ommen represented by Carrie Mears (IA); Gary D. Anderson represented by John Turchi (MA); Kathleen A. Birrane (MD); Chlora Lindley-Myers and also representative John Rehagen (MO); Bruce R. Ramge represented by Justin Schrader (NE); Linda A. Lacewell represented by Bill Carmello (NY); Jessica K. Altman (PA); Raymond G. Farmer represented by Daniel Morris (SC); Carter Lawrence (TN); Doug Slape represented by Mike Boerner (TX); and Scott A. White represented by Don Beatty (VA).

1. **Heard Opening Remarks**

Commissioner Caride said that materials for consideration and discussion for this meeting were sent by email to the member, interested state insurance regulator and interested party distribution lists for the Task Force and the Liquidity Assessment (E) Subgroup, but are also available on the Task Force’s web page at www.naic.org. She added that the Task Force now reports to the Financial Condition (E) Committee.

2. **Adopted its Oct. 13, 2020, Minutes**

The Task Force met Oct.13, 2020, and took the following action: 1) adopted its 2020 Summer National Meeting Minutes; 2) adopted its 2021 proposed charges; 3) adopted proposed Liquidity Stress Test (LST) revisions to the Insurance Holding Company System Regulatory Act (#440); and 4) received an update from the Liquidity Assessment (E) Subgroup on progress in achieving its deliverables related to liquidity stress testing.


3. **Announced the Membership of the 2021 Liquidity Assessment (E) Subgroup and its Charges**

Commissioner Caride announced the membership of the Liquidity Assessment (E) Subgroup and the Subgroup’s charges (Attachment One). She asked new member states to consider membership and participation in the Subgroup and its unofficial study group dedicated to the LST. She also thanked Mr. Schrader for his continued leadership of the Subgroup, the unofficial Study Group, and the significant work related to establishing and maintaining the LST framework.

4. **Received the Report of the Receivership and Insolvency (E) Task Force Regarding its Disposition of Referrals from the Financial Stability (E) Task Force**

Commissioner Caride said that a copy of the final report of the Receivership and Insolvency (E) Task Force on its work to address the Financial Stability (E) Task Force’s referral letter to undertake analysis relevant to recovery and resolution concerns within the Macroprudential Initiative (MPI) was included in the information distributed for this meeting.

She noted that the Financial Stability (E) Task Force asked the Receivership and Insolvency (E) Task Force to evaluate:

- Recovery and resolution laws, guidance, and tools, and determine whether they incorporate best practices with respect to financial stability;
- Recovery and resolution planning tools for systemically important cross-border U.S. groups; and
- Whether there are misalignments between federal and state laws that could be an obstacle to effective and orderly recovery and resolutions for U.S. insurance groups.

Commissioner Caride said that the report describes the completed recommendations but also indicates where further work will occur. She thanked the Receivership and Insolvency (E) Task Force for its work and James Kennedy (TX) for his role as its representative to the Financial Stability (E) Task Force.
Commissioner Altman made a motion, seconded by Mr. Carmello, to receive a copy of the final report of the Receivership and Insolvency (E) Task Force on its work to address the Financial Stability (E) Task Force’s referral letter (Attachment Two). The motion passed unanimously.

5. **Adopted the Accreditation Recommendations to the Financial Condition (E) Committee regarding the LST changes to Model #440**

Commissioner Caride referenced the draft recommendation to the Financial Condition (E) Committee regarding LST changes to Model #440 included in the materials and said that the draft recommends the LST revisions to Model #440 be included as required for accreditation purposes. She noted that the Task Force supports having states, particularly the lead states of insurers in scope, adopt the LST revisions to the Model #440 quickly but concluded that the Financial Regulation Standards and Accreditation (F) Committee will decide the timing. While no member disagreed with this conclusion, Mr. Boerner noted the Texas DOI has concerns about the accreditation timing considerations which will be discussed at the Financial Condition (E) Committee.

Commissioner Caride said that the American Council of Life Insurers (ACLI) requested that each detailed confidentiality provision included in the LST revisions to Model #440 be given the designation as “significant elements” to ensure the same levels of confidentiality associated with the Risk Management and Own Risk and Solvency Assessment Model Act (#505) be preserved when the revisions to Model #440 are adopted by the states. She concluded that providing the same confidentiality protection makes sense and proposed a revision to consider for the Attachment A language within the Task Force’s draft recommendation to the Financial Condition (E) Committee. She said that adding the yellow highlighted paragraph with the underscored additions to this Attachment A language would align the language with the equivalent significant elements in the Own Risk and Solvency Assessment (ORSA) accreditation standard. Commissioner Caride stressed the need to balance the desire for exact language with the practicality of obtaining such language due to implementation concerns in the different legislatures across the country. She concluded that the language provides good confidentiality protections while avoiding implementation issues. David Leifer (ACLI) said that the new language looks reasonable at an initial glance, but he said he will need to seek industry feedback during the comment periods at the Financial Condition (E) Committee and/or Financial Regulation Standards and Accreditation (F) Committee.

Mr. Rehagen made a motion, seconded by Mr. Schrader, to adopt the previously exposed recommendations to the Financial Condition (E) Committee with the addition of the yellow highlighted paragraph, including the underscored items, to its Attachment A and to send it to the Financial Condition (E) Committee for consideration (Attachment Three). The motion passed unanimously.

Having no further business, the Financial Stability (E) Task Force adjourned.
2021 Adopted Charges

LIQUIDITY ASSESSMENT (E) SUBGROUP

Ongoing Support of NAIC Program, Products or Services

The Liquidity Assessment (EX) Subgroup will:

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

MEMBERSHIP

Liquidity Assessment (E) Subgroup of the Financial Stability (E) Task Force

Justin Schrader, Chair
Kathy Belfi/John Loughran
Philip Barlow
Ray Spudeck
Shannon Whalen
Carrie Mears
Fred Andersen
John Rehagen
Mike Boerner/Jamie Walker

Nebraska
Connecticut
District of Columbia
Florida
Illinois
Iowa
Minnesota
Missouri
Texas

NAIC Support Staff: Todd Sells/Tim Nauheimer
The following report summarizes the conclusions of the Receivership and Insolvency (E) Task Force (RITF) in response to the Macroprudential Initiative (MPI) referral on recovery and resolution. While the RITF has completed its recommendations, the RITF will conduct further work on the issues as described below.

1. Evaluate recovery and resolution laws, guidance, and tools, and determine whether they incorporate best practices with respect to financial stability

The Receiver’s powers under laws based on the Insurer Receivership Model Act Model #555 (IRMA) and its predecessor, the Insurer Rehabilitation and Liquidation Model Act (IRLMA), in conjunction with the authority granted to the Receiver by court orders, generally provide the powers described in:

- International Association of Insurance Supervisors (IAIS) Insurance Core Principle (ICP) 12, Exit from the Market and Resolution;
- Common Framework for the supervision of Internationally Active Insurance Groups (ComFrame) material integrated into ICP 12; and
- Financial Stability Board (FSB) Key Attributes of Effective Resolution Regimes for Financial Institutions (KAs).

While powers under state laws comport with the ICPs, ComFrame, and the KAs, in some cases the powers are implicit rather than explicit. The RITF reviewed current laws with respect the following issues:

a. Bridge Institutions

State receivership laws do not expressly provide for the establishment of a bridge institution (Bridge), but the Receiver may establish a Bridge under those laws. While a Bridge is typically not needed in a receivership, it could have the benefit of addressing an early termination on qualified financial contracts (QFCs). However, implementing a Bridge for this purpose would require a temporary stay on termination rights. As noted in Item 3 below, the current misalignments with Federal rules on the termination of master netting agreements for QFCs effectively precludes temporary stays on termination of QFCs in a receivership, thereby preventing the use of a Bridge for this purpose.

Conclusion: The Receivership Law (E) Working Group reviewed guidance in the Receiver’s Handbook for Insurance Company Insolvencies (Receivers Handbook) and developed revisions to guidance regarding the use of bridge institutions and administration of QFCs in receivership and pre-receivership planning.

b. Providing Continuity of Essential Services and Functions

KA 3.2 states that a resolution authority should have the power to ensure the continuity of essential services and functions by requiring companies in the group to continue providing services. Under ComFrame (CF) 12.7a, a resolution authority may take steps to provide continuity of essential services by requiring other entities within the IAIG (including non-regulated entities) to continue services. The following authority and tools were identified:
• The Insurance Holding Company System Model Act (#440) requires approval of affiliated transactions, allowing a regulator to identify agreements that could create obstacles in a receivership. The Insurance Holding Company System Model Regulation (#450), Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.

• The Receiver can take action against a provider that refuses to continue services under a contract, or seek an order requiring it to turn over records. In some circumstances, such as a situation where an affiliate providing services is inextricably intertwined with the insurer, action can be taken to place the affiliate into receivership.

It was noted that some of these remedies might not address the immediate need to continue services in some cases. Therefore, the Task Force delegated further work on this topic to the Receivership Law (E) Working Group.

Conclusion: The Receivership Law (E) Working Group is developing, among other solutions, revisions to Models 440 and 450 to address remedies to ensure continuity of essential services and functions to an insurer in receivership by other affiliated entities in a holding company group, including non-regulated entities. The Model Law Request to develop revisions to Models 440 and 450 was adopted by Executive (EX) Committee in August 2020. The Working Group expects to finalize its work in this area in 2021.

c. Variations in States’ Receivership Laws

The RITF recognized that few states have adopted IRMA, and most have laws based on IRLMA or prior models. In 2017, the Financial Condition (E) Committee issued a memorandum to states to consider adoption of certain provisions of IRMA.1 The RITF further identified eight key areas within receivership and guaranty fund law that it encourages states to adopt. The key areas include: conflicts of law; continuation of coverage; priority of distribution; stays and injunctions; ancillary conservation of foreign insurers; domiciliary receivers in other states; treatment of large deductible workers compensation policies; and the 2017 revisions to the Life and Health Insurance Guaranty Association Model Act (#520). The RITF also determined that some states may require an alternative solution to revise their laws for stays, injunctions and “full faith and credit” provisions. Therefore, the RITF recommends redefining “reciprocal state” in states’ receivership law as an optional solution. The RITF concluded the following:

Conclusion:
• The RITF developed a Model Guideline defining “reciprocal state” that was released for exposure at the Nov. 19, 2020, virtual meeting, and which will be considered for adoption in 2021.
• The RITF will work towards educating states on key areas of receivership and guaranty fund laws that enhance efficiencies and effectiveness of the receivership process, as identified through this workstream, including related new Model Guidelines adopted by the NAIC, outreach to states’ legal staff and other educational opportunities.
• The RITF formed an ad hoc group to discuss Financial Regulation Standards and Accreditation Program Part A standards for receivership and guaranty fund laws and will take any recommendations from the ad hoc group under consideration in the future.

2. Evaluate recovery and resolution planning tools for systemically important cross-border U.S. groups

The RITF determined that many recovery and resolution planning topics in the KAs and ComFrame are generally covered in the guidance for pre-receivership planning in the Receiver’s Handbook. Additionally, some topics were identified that may be captured elsewhere within the US solvency monitoring frameworks (e.g., ORSA, Supervisory Colleges, Crisis Management Groups, Examinations, etc.). The RITF found that:
• The Dodd Frank Act’s provisions for resolution planning address the requirements of the KAs and ComFrame for an insurer designated as a Systemically Important Financial Institution (SIFI). Other jurisdictions may have similar planning requirements for international groups.
• The requirements in state laws for corrective action plans under risk-based capital (RBC) laws and hazardous financial condition laws may satisfy this requirement for insurers that fall short of the applicable RBC solvency benchmarks, or otherwise trigger a corrective action requirement.

- Regarding crisis management groups and crisis management planning, the NAIC *Insurance Holding Company System Model Act* (#440) Section 7 provides the commissioner with the authority to develop crisis management plans as part of supervisory colleges. Further, Model 440 Section 7.1, provides for authority for the commissioner to act as the group-wide supervisor of internationally active insurance groups (IAIG) and engage in group-wide supervision activities as outlined in the model, though not explicit to recovery and resolution plans. Additionally, the NAIC *Financial Analysis Handbook* contains guidance and a template for a crisis management plan. This authority and guidance provide states with the flexibility to discuss the necessity for crisis management plans within supervisory colleges and/or crisis management groups and to make the determination to develop such plans on a case-by-case basis.

**Conclusion:**
- The RITF agreed that consideration of imposing recovery plan reporting requirements on insurers that are not in financial distress is outside the scope of the RITF and may require consideration by U.S. group-wide supervisors of IAIGs.
- The Group Solvency Issues (E) Working Group is undertaking a project to update insurance regulatory guidance as it pertains to supervision of IAIGs under ComFrame, including guidance on crisis management groups. The RITF will provide input at the appropriate time to this work stream. The Working Group’s project is expected to be completed in 2021.
- The RITF will continue to review and provide input to the IAIS on recovery and resolution topics including the upcoming Application Paper on Resolution Powers and Planning.

3. **Evaluate whether there are misalignments between federal and state laws that could be an obstacle to effective and orderly recovery and resolutions for U.S. insurance groups**

a. **Temporarily Stay Early Termination Rights**

The Task Force evaluated the impact of the federal rule recognizing temporary stays on terminating master netting agreements for qualified financial contracts (QFCs), which does not recognize stays in a state receivership proceeding. The regulators held discussions with federal banking authorities regarding the handling of QFCs and bridge institutions in banking resolutions. This information will be used to assess the utility of a stay on QFC terminations in an insurance receivership.

**Conclusion:**
- In 2019, the NAIC adopted amendments to the Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts (#1556) to highlight the conflict with the federal rule to state insurance regulators who may be considering adoption of Guideline #1556.
- The Task Force adopted revisions to existing guidance for receiverships involving qualified financial contracts at the Nov. 19, 2020 virtual meeting.

b. **Taxes in Receivership and Federal Releases**

The Task Force identified topics where guidance for taxes in receivership and federal releases should be drafted in the Receiver’s Handbook.

**Conclusion:** The RITF adopted revisions to the Receiver’s Handbook for guidance on taxes in receivership and federal releases at the 2020 Summer National Meeting.
The confidentiality of the LST (and the Group Capital Calculation (GCC)) calculation, including information shared with the Federal Reserve or international regulators, is highly important to our members. The memo’s proposed list of “significant elements” of the 2020 revisions to the Model Act and Regulation includes one confidentiality-related element, item “m”, which prohibits insurers from sharing information about the LST or GCC to advertise. ACLI supports the inclusion of this section in the standards, but we believe additional significant elements are warranted.

ACLI strongly prefers that the significant elements for accreditation incorporate all of the substantive revisions made to section 8. At a minimum, the significant elements should also include these items:

- provisions for maintaining the confidentiality of LST (or Group Capital Calculation) materials submitted to the Department (section 8(A)(1) and (2));
- deem section 8(A)(2) a “significant element”, as section 8(A)(2) protects the confidentiality of liquidity stress test results and data;
- provisions for information sharing agreements that maintain the confidential and privileged status of the documents (section 8(C)(4)(a));
- provisions exclude materials or information collected through the liquidity stress test from being stored in a permanent database once the initial analysis is completed (8(C)(4)(c)); and
- provisions requiring notification and identification of third-party consultants who will receive LST materials (8(C)(4)(f))

Similar confidentiality protections, such as the from the Own Risk Solvency Act (#550) are already afforded status as “significant elements” of the “substantially similar” accreditation status. Given that most states have already enacted similar confidentiality provisions for ORSA materials – it is reasonable to expect the same levels of confidentiality for the LST and GCC related materials.

Conclusion
Thank you for the opportunity to share our comments on the exposed Financial Stability Task Force memo. ACLI always appreciates the chance to engage with the NAIC on this important issue. If you have any questions or concerns about our comments, please feel free to contact us. We look forward to continuing to work together in the future.

Sincerely,

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1 The significant elements from the Own Risk Solvency Assessment (#505) accreditation standard require states to: “Include substantially similar provisions for protecting confidential information submitted to the commissioner, including provisions maintaining confidentiality for information shared with state, federal and international regulators. If sharing confidential information with the NAIC and third-party consultants is permitted, appropriate confidentiality protections should be included.”

https://content.naic.org/sites/default/files/inline-files/committees_f_orsa_significant_elements.
6. Insurance Holding Company Systems

State law should contain the NAIC Insurance Holding Company System Regulatory Act (#440), or an act substantially similar.

Insurance Holding Company Systems – continued

Changes to Existing

k. Additions to the filing requirements for the enterprise risk filing specified in Section 4L(1) of the Model #440 (see next item).

New

c. Define “NAIC Liquidity Stress Test Framework” similar to that in Section 1K?

d. Define “Scope Criteria” similar to that in Section 1M?

l. Filing requirements for the liquidity stress test filing similar to those specified in Section 4L(3) of Model #440:

i. The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC Liquidity Stress Test Framework shall file the results of a specific year’s Liquidity Stress Test to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook similar to Section 4L(3)?

ii. Insurers meeting at least one threshold of the Scope Criteria for a specific data year are scoped into that year’s NAIC Liquidity Stress Test Framework unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should not be scoped into the Framework for that data year similar to Section 4L(3)(a)? Insurers that do not trigger at least one threshold of the Scope Criteria are considered scoped out of the NAIC Liquidity Stress Test Framework for the specified data year, unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should be scoped into the Framework for that data year?

iii. Provision requiring compliance with the NAIC Liquidity Stress Test Framework’s instructions and reporting templates for the specific data year and any lead state insurance commissioner determinations in consultation with the Financial Stability Task Force or its successor, provided within the Framework similar to Section 4L(3)(b)?

Changes to Existing

c. Provisions for protecting confidential information submitted to the commissioner, including provisions maintaining confidentiality for information shared with state, federal and international regulators similar to Section 8? If sharing confidential information with the NAIC and third-party consultants is permitted, appropriate confidentiality protections should be included.

m. Provision prohibiting the making, publishing, disseminating, circulating or placing before the public in any way the group capital calculation and resulting group capital ratio under Section 4L(2) and/or the liquidity stress test along with its results and supporting disclosures required under Section 4L(3), by any insurer, broker, or other person engaged in any manner of the insurance business, except if the sole purpose of the announcement is to rebut a materially false statement, similar to Section 8G of Model #440?
RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) and National Conference of Insurance Guaranty Funds (NCIGF) Amendments to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) (Attachment One-A1a) ............ 10-869
Exposure for Model #440 and Model #450 (Attachment One-A1b)................................................................. 10-871
Comment Summary and Comments Regarding Model #440 and Model #450 (Attachment One-A2)......... 10-933
Letters to the Receivership Law (E) Working Group (Attachment One-B)...................................................... 10-950
Guideline for Definition of Reciprocal State in Receivership Laws (Attachment Two)..................................... 10-961
The Receivership and Insolvency (E) Task Force met March 12, 2021. The following Task Force members participated: Doug Slape, Chair, represented by James Kennedy (TX); James J. Donelon, Vice Chair (LA); Andrew N. Mais represented by Jared Kosky (CT); David Altmaier represented by Toma Wilkerson (FL); Colin M. Hayashida represented by Patrick P. Lo (HI); Dana Popish Severinghaus represented by Kevin Baldwin (IL); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Jeff Gaither (KY); Gary D. Anderson represented by Christopher Joyce (MA); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox represented by James Gerber (MI); Chlora Lindley-Myers (MO); Mike Causey represented by Jeff Trendel (NC); Bruce R. Ramge represented by Lindsay Crawford (NE); Russell Toal (NM); Glen Mulready and Donna Wilson (OK); Jessica K. Altman represented by Laura Lyon Slaymaker (PA); Elizabeth Kelleher Dwyer (RI); and Raymond G. Farmer represented by Michael Shull (SC).

1. **Adopted its Nov. 19, 2020, Minutes**

Superintendent Toal made a motion, seconded by Commissioner Donelon, to adopt the Task Force’s Nov. 19, 2020, minutes (see NAIC Proceedings – Fall 2020, Receivership and Insolvency (E) Task Force). The motion passed unanimously.


Ms. Wilson said the Receivership Financial Analysis (E) Working Group met Feb. 1 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss experiences and the need for best practices for data transfer from insurance companies in liquidation to guaranty funds. The Working Group will draft a referral to the Information Technology (IT) Examination (E) Working Group to review and consider enhancements to the *Financial Condition Examiner’s Handbook* IT workplan. If the Task Force forms a subgroup to update the *Receiver’s Handbook for Insurance Company Insolvencies* (Receiver’s Handbook), these topics could be considered by that subgroup. The Receivership Financial Analysis (E) Working Group plans to meet March 22 in lieu of the Spring National Meeting in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.

Ms. Wilson made a motion, seconded by Commissioner Donelon, to adopt the Working Group’s report. The motion passed unanimously.


Mr. Baldwin said the Receivership Law (E) Working Group met Feb. 4, 2021; Dec. 17, 2020; and Dec. 17, 2020. The Working Group also met Feb. 18, 2021, in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings. During these meetings, the Working Group exposed draft amendments to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) for public comment and received comments. On its March 4 meeting, the Working Group agreed to make further revisions to one section of Model #440. Those revisions have been released for a 30-day public comment period ending April 9.

Mr. Baldwin made a motion, seconded by Mr. Wake, to adopt the Working Group’s report (Attachment One). The motion passed unanimously.

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

Mr. Kennedy said the draft Guideline provides an optional definition of “reciprocal state” for receivership laws that is intended to effectuate the recognition of stays and injunctions in a receivership impacting multiple states. He noted that while some states have updated the reciprocity provisions in their receivership laws, many state laws have a definition based on a prior NAIC receivership model that is inconsistent with newer models. The Guideline’s definition is consistent with the Part A Accreditation Standards for receivership laws; if a state has a receivership scheme, it would be considered a reciprocal state. As it is a Guideline, it is optional and is not required to be adopted in all states.
Mr. Kennedy said the Task Force drafted the *Guideline for Definition of Reciprocal State in Receivership Laws* (Guideline) in November and exposed it for a 42-day public comment period ending Dec. 31, 2020. He said no comments were received.

Superintendent Toal made a motion, seconded by Mr. Wake, to adopt the Guideline (Attachment Two). The motion passed unanimously.

5. **Appointed the Receiver’s Handbook (E) Subgroup and Adopt its 2021 Proposed Charges**

Mr. Kennedy said that it has been over 10 years since the last comprehensive update of the Receiver's Handbook for Insurance Company Insolvencies Handbook. The Task Force made edits and additions to the Handbook since then, and in that process found that there was outdated information in the Handbook. He said that an update of the Handbook would require commitment from Task Force members, as well as the expertise of regulators and others with experience in handling receiverships. Mr. Kennedy asked if there was any discussion on the proposal to create the Receiver’s Handbook (E) Subgroup to review and update the Handbook, and several Task Force members expressed support for the project. He proposed the following charges for the Subgroup:

   The Receiver’s Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force will:
   
   1. Review the *Receiver's Handbook for Insurance Company Insolvencies* (Handbook) to identify areas where information is outdated, updates are required, or additional guidance is needed. Based on this review, draft recommended edits to the Handbook.
   2. Complete by the 2022 Fall National Meeting.

Mr. Gerber made a motion, seconded by Ms. Wilson, to appoint the Receiver’s Handbook (E) Subgroup and adopt its 2021 proposed charges. The motion passed unanimously.

Mr. Kennedy asked for volunteers to participate on the Receiver’s Handbook (E) Subgroup. Florida, Illinois, Michigan and Oklahoma volunteered to participate. Others who wish to volunteer should notify NAIC staff.

6. **Heard an Update on the Status of MPI Recommendations**

   a. **Part A: Accreditation Standards for Receivership and Guaranty Fund Laws**

   Mr. Kennedy said the Task Force reported at its Nov. 19, 2020 meeting that an ad hoc group had discussed the possibility of developing additional interpretive guidance in the accreditation interlineations to clarify the Part A accreditation standards for receivership and guaranty fund laws. Since then, regulators and NAIC staff identified potential concerns that guidance could be misinterpreted or have unintended consequences. Therefore, the Task Force will not be considering any proposals to clarify the accreditation interlineations or the standards at this time.

   b. **Training and Outreach to State Insurance Departments**

   Mr. Kennedy said the Task Force should consider pursuing more training and outreach to better inform state insurance departments of receivership matters. He suggested possible options, including outreach to state insurance departments’ legislative liaisons, providing legal training webinars, and encouraging that Task Force members highlight receivership matters at zone meetings. He said Task Force members will be asked to assist in developing training and other materials.

   c. **Monitor the Work of Other NAIC Groups**

   Mr. Kennedy said the Group Solvency Issues (E) Working Group is making progress drafting updates to financial analysis guidance regarding crisis management groups, recovery planning, and resolution planning. When available, the guidance will be circulated to the Task Force for feedback.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.

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The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force met March 4, 2021. The following Working Group members participated: Kevin Baldwin, Co-Chair (IL); Laura Lyon Slaymaker, Co-Chair (PA); Steve Uhrynowycz (AR); Jack Hom (CA); Jared Kosky (CT); Toma Wilkerson (FL); Tom Travis (LA); Christopher Joyce (MA); Robert Wake (ME); James Gerber (MI); Shelley Forrest (MO); Lindsay Crawford (NE); James Kennedy (TX); and Melanie Anderson (WA).

1. **Adopted its Feb. 4 Minutes**

   The Working Group met Feb. 4 to receive comments and re-expose draft amendments to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) for a 14-day public comment period ending Feb. 26.

   Mr. Uhrynowycz made a motion, seconded by Ms. Wilkinson, to adopt the Working Group’s Feb. 4 minutes (Attachment One-A). The motion passed unanimously.

2. **Discussed Comments Received on Amendments to Model #440 and Model #450**

   Mr. Baldwin said during its Feb. 4 meeting, the Working Group discussed comments received on the exposed draft amendments to Model #440 and Model #450. The Working Group agreed to draft additional edits and re-expose the amendments for an additional 14-day public comment period ending Feb. 26. The amendments are intended to ensure the continuity of essential services and functions by affiliates in receivership. Comments on Model #440 were received from America’s Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA); the American Property Casualty Insurance Association (APCIA); Arbor Strategies LLC; and the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) and the National Conference of Insurance Guaranty Funds (NCIGF) (Attachment One-B).

   a. **Model #440, Section 5(A)(1)(g) and Section 11(D)**

      Mr. Baldwin said the commentors offered revised language for Section 5A(1)(g). The drafting group reviewed these suggestions and agreed to limit the requirement to insurers that are deemed to be in hazardous financial condition or a condition that would be grounds for supervision, conservation or delinquency proceedings. However, the drafting group recognized that once a company is in a hazardous financial condition, it may be difficult or impossible to secure a bond. The drafting group recommended changing the requirement to a deposit held by the commissioner. Bob Ridgeway (AHIP) expressed several concerns with a deposit rather than a bond, such as who holds the deposit, how the deposit is protected, who receives interest on the deposit, accounting treatment, tax treatment, and when the deposit would be returned. Chris Petersen (Arbor Strategies LLC) said the requirement should be on the insurer, rather than the affiliate, to avoid enforcement issues. Mr. Kennedy suggested replacing the deposit with the original bond. Mr. Wake suggested a bond or deposit requirement. Mr. Wake and Mr. Kosky agreed that the Working Group should redraft the paragraph rather than move forward with adopting the models on this call. Mr. Baldwin said the drafting group would redraft language for Section 5A(1)(g).

      Mr. Baldwin said given the changes to Section 5A(1)(g), the drafting group recommended deleting the proposed Section 11(D), which would have imposed a bond requirement as a sanction. Hearing no objection, the deletion was accepted.

   b. **Model #440, Section 5(A)(1)(h)**

      Mr. Baldwin said the sentence on “commingling of premium and funds” in Section 5A(1)(i) was removed since on the last call, it was recognized that all the interested parties were opposed; instead, “offset” language had been added with the previous exposure draft. Hearing no objection, the deletion was accepted.
c. Model #440, Section 5(A)(6)

Ms. Slaymaker said the NOLHGA and the NCIGF’s comment letter recommended clarifying language as to how this provision would work with respect to conflicts with other regulatory authorities and jurisdictions. Bill O’Sullivan (NOLHGA) said the recommended edits clarify that the intent of the section is to narrowly address essential services by affiliates and clarify that the requirement for consent to the jurisdiction be discretionary. Hearing no objection, the additions were accepted.

Having no further business, the Receivership Law (E) Working Group adjourned.
The Receivership Law (E) Working Group met Feb. 4, 2021. The following Working Group members participated: Kevin Baldwin, Co-Chair (IL); Laura Lyon Slaymaker, Co-Chair (PA); Steve Uhrynnowycz (AR); Joe Holloway and Jack Hom (CA); Jared Kosky (CT); Toma Wilkerson (FL); Robert Koppin (IA); Christopher Joyce (MA); Robert Wake (ME); James Gerber (MI); Shelley Forrest (MO); Lindsay Crawford (NE); James Kennedy (TX); and Melanie Anderson (WA).

1. **Adopted its Dec. 17, 2020, Minutes**

The Working Group met Dec. 17, 2020, and exposed draft amendments to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) for a 42-day public comment period ending Jan. 29.

Ms. Crawford made a motion, seconded by Ms. Forrest, to adopt the Working Group’s Dec. 17, 2020, minutes (Attachment One-A1). The motion passed unanimously.

2. **Discussed Comments Received on Amendments to Model #440 and Model #450**

Ms. Slaymaker said during its Dec. 17, 2020, meeting, the Working Group exposed draft amendments to Model #440 and Model #450 for a 42-day public comment period ending Jan. 29. The amendments are intended to ensure the continuity of essential services and functions by affiliates in receivership. Comments were received from Florida; the American Council of Life Insurers (ACLI); America’s Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA); Arbor Strategies LLC; Morgan, Lewis & Bockius LLP; and the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) and the National Conference of Insurance Guaranty Funds (NCIGF) (Attachment One-A2).

   a. **Model #440, Section 5(A)(1)(g) and Section 11(D)**

Ms. Slaymaker said the proposed addition of Section 5(A)(1)(g) places a bond requirement on affiliated transactions, the amount of which would be at the discretion of the commissioner. The consensus of interested party comments opposes the amendment, as it places the requirement on all insurers, most of which are not financially troubled and would not result in receivership; it may create competitive disadvantages; it implies bias; and it creates an additional cost to insurers.

Chris Petersen (Arbor Strategies LLC) said he does not understand why affiliated contracts are differentiated from contracts with other companies. He said health care groups are very integrated, and performance bonds could be very expensive; i.e., 1–3% of the cost. He suggested that there may be a better place to regulate this issue.

Joseph E. Zolecki (BCBSA) said the number of receiverships has declined over the years, and it represents a very small percentage of companies, which highlights that the solvency monitoring regime is working. He said solvency initiatives over the years have built up tools for financial solvency regulation and the identification of troubled companies. Risk-based capital (RBC) allows for early intervention and the authority to take corrective measures, thereby minimizing the adverse impact on solvency. Mr. Zolecki said he has questions about affiliate versus non-affiliate. He said if the cost of a performance bond is offset by the value to receivers, then he believes the bond requirement should be applicable only to those insurers that pose an imminent risk of insolvency. He said strong carriers should be exempt from bond requirements, and they should not be penalized because there might be a misunderstanding that all organizations with vertical integration pose a greater risk. He said consumers should be shielded from additional costs. He said the BCBSA might propose that the Working Group consider a separate company action level RBC threshold for performance bonds with direction from the Capital Adequacy (E) Task Force. He said a lot of qualitative and quantitative triggers have been added besides RBC for state insurance regulators’ use with more information on groups and insurers as part of the risk-focused analysis and examination processes. He recommends a separate trigger for bond requirements that is supported by the solvency monitoring process, which is tailored to the insurers with the highest level of insolvency, and does not unduly penalize ongoing strong carriers because of their level of vertical integration. He asked why this issue is not being addressed in the *Insurer Receivership Model Act* (#555).
Mr. Gerber said the bond should be at the commissioner’s discretion based on the solvency items, just as the BCBSA mentioned. He agreed that it should not be placed on all insurers. He said some states currently require third-party administrators (TPAs) to have performance bonds be licensed. He explained his experience as a receiver performing work in a receivership that a TPA would perform, where he had to get licensed as a TPA. Some states required him to put up a performance bond to be licensed as a TPA. Mr. Petersen asked if the bond requirement was a one-time bond or a bond for each contract. Mr. Gerber said it was on a state-by-state basis; the bond was not on each contract, and it was renewable annually when the license was renewed. He said if the commissioner has discretion, based on analysis or RBC as mentioned, he does not believe it would result in financially stable companies having to put up a bond for their affiliated contracts. Mr. Petersen said the proposed amendments require a bond for each contract. He said some of the suggestions seem reasonable, and he suggested clarification for the difference between a bond to get a license versus a bond on every new contract. Mr. Gerber said one size does not fit all, so if the commissioner has discretion, then the bond requirement could be limited to one contract or one affiliate and the commissioner could determine the type of bond. Mr. Petersen said that would be an improvement over the current proposed language.

Mr. Kennedy suggested expanding the drafting note for this paragraph to explain the circumstances in which a commissioner may decide to require a bond to address these concerns.

Mr. Baldwin said he agrees with Mr. Kennedy that we can address the comments with some redrafting.

Mr. Wake agreed, and he said the language should not create too much disparity between intra-group transactions and outside contractors, such that it would push companies to use outside contractors. He said it might be worth considering in some cases if we need to tighten up the standards for outside contractors.

Ms. Wilkerson said the paragraph was not intended to punish entities that use affiliates; but if it is a third-party agreement, there is due diligence performed to determine the financial status of that third party. She said it is not typical that the insurer is an outside party’s only revenue stream. She said where the insurer is the affiliate’s only revenue stream, once the insurer is in liquidation and the revenue stream is gone, which is usually a percentage of premium, there is no way to run-off that business. She said at the point that there is a solvency issue, the commissioner may be discouraged from adding the burden of obtaining the bond, which is why it was drafted to have the bond up front. She said the trigger for the bond could be if the affiliate is a single revenue stream.

Ms. Slaymaker suggested that NAIC staff draft some revisions to tighten up the provision.

1. **Model #440, Section 11(D)**

Ms. Slaymaker said one comment was received from the ACLI on the related bond provision in Section 11(D). She said the ACLI believes that the remedy is unlikely to be used because an insurer would simply seek regulatory approval of the transaction after the fact. Lauren Sarper (Prudential) said she does not oppose the provision in Section 11(D), but to have a bond for an agreement that is not properly approved might be punitive. She said insurers pursue regulatory approval on these items after the fact. Andrew Hughes (Prudential) said a commissioner has the authority to disapprove an agreement if it is not within the interest of policyholders and the bond requirement is therefore not necessary. Ms. Slaymaker suggested that NAIC staff draft some revisions to tighten up the provision like Section 5(A)(1)(g).

2. **Model #440, Section 5(A)(1)(h)**

Ms. Slaymaker said the proposed addition of Section 5(A)(1)(h) states that records and data held by the affiliate is the property of the insurer. She said comments were received from the ACLI questioning the last two sentences of the provision. A comment from Florida suggests that additional wording relates to separating records and data “at no cost to the insurer.” She said Morgan, Lewis & Bockius LLP suggests alternative language.

Harold S. Horwich (Morgan, Lewis & Bockius LLP) said just saying the data is property of the insurer and that the data will be made available is not enough. The paragraph needs to say the state insurance regulator should be able to get a complete set of data and that at the point when the affiliate is no longer performing services, the affiliate should be unable to use that data for its own purposes. He said the draft is not wrong, but it does not reflect how the data is maintained in an affiliate’s system.

Ms. Slaymaker said Florida suggested adding “at no cost to the insurer” to the proposed paragraph. Ms. Wilkerson explained an example where the affiliate did business with multiple insurers. At the point of liquidation, it was important that the receiver
have access to see the claims, coverage and policyholder records of the insurer even while the data was being extracted. If the data was not segregated, the receiver could see other insurers’ data, which was not the intent, but it was an issue.

Patrick Cantilo (Cantilo & Bennett LLP) said once it is qualified, all the records and data are the property of the insurer; other tools will accomplish the purpose being discussed. The typical receivership order will grant the receiver complete access to all the company’s records and property. The order typically authorizes the commissioner to exercise exclusive or shared control, if appropriate. Characterizing the records as property of the insurer triggers other available tools, so additional language may not be required.

Ms. Sarper said it is unlikely that the insurer would be able to access the affiliate’s systems. There may be conflicting legal rights. It is reasonable as Mr. Horwich suggested, that the receiver can get a complete set of data. She said regarding the “at no cost” language suggested by Florida, those costs would be passed on to the insurer directly or indirectly.

Ms. Slaymaker requested that NAIC staff draft some revisions to this section based on the discussion.

d. **Model #440, Section 5(A)(1)(i)**

Mr. Baldwin said the proposed addition of Section 5(A)(1)(i) addresses premiums or other funds belonging to the insurer, and it specifies that the affiliate shall not commingle the insurer’s premium and funds with other accounts. He said comments from interested parties on this section oppose the commingling provision. He said the ACLI’s comment indicates that it is unlikely and impractical. He said AHIP and the BCBSA opposed the commingling language, and they suggested instead that there should be an ability to identify the various funds’ ownership rights, which may already be covered in the previous section. He said Arbor Strategies LLC opposes the language, and he asked for clarity on what is included in “other funds.” He said the comments from Morgan, Lewis & Bockius LLP encompass several concepts, including that the amendments related to commingling are not clear as to whether the rights being established eliminate the contractual offset rights. He said one commentor said the term “other funds” may be vague.

Mr. Horwich said if what is meant in this paragraph is that when a group gets into financial trouble, the state insurance regulator can step in and take the premium regardless of rights of the affiliate, the provision should state that. However, he said he is not advocating for that. He said for example, bank accounts and homes may be the exclusive property of a person, but the bank has the right to offset and a valid interest in the mortgage. Mr. Baldwin asked if regarding what Mr. Horwich is referring to, this provision is a general requirement and the precision is in the state’s receivership act. Also, the provisions within the receivership order address the precision. He said language in the receivership act would not eliminate another party’s lien or offset rights. He suggested more clarity in this language.

Mr. Cantilo said characterizing the premiums and funds as exclusive property does not address either way the applicability of offsets. Calling it exclusive property gives the receiver some right to the premium and other funds. The counterparty may also have contractual rights, and whether those rights are eligible for offset is then governed by the provisions of the liquidation act, which promulgates several requirements before credits and debits may be offset.

Mr. Baldwin said we will consider some revisions to this section.

e. **Model #440, Section 5(A)(6)**

Mr. Baldwin said Section 5(A)(6) is the new language that addresses that the affiliated agreement specifies that the affiliates consent to the receivership court. He said the ACLI had a comment on this section. Ms. Sarper said she supports the goals of the section and especially to consolidate court proceedings in a single jurisdiction, but she asked how this section might handle certain situations where affiliates may not recognize the jurisdiction even though they sign the agreements and how this might work with certain assets management affiliates and any regulatory conflicts with the asset manager’s state insurance regulators (e.g., Financial Industry Regulatory Authority (FINRA) or the U.S. Securities and Exchange Commission [SEC]). The state insurance regulators might want to give some additional consideration to that point. The goal is to reduce potential delays and concentrate everything in a single court jurisdiction, so we want to avoid potential conflicts that could make the process more complicated.

Bill O’Sullivan (NOLHGA) said the NOLHGA has been thinking about these issues, and he offered his assistance to address these issues.
f. **Model #450, Section 19(B), Paragraphs 6, 7, 11(b) and 13**

Mr. Baldwin said Section 19 addresses the provisions that should be included in an affiliated transaction agreement. He said the comments on several paragraphs in this section relate to providing the records and data “at no cost to the insurer.” The commentors ask if this is an unreasonable or impractical expectation. Ms. Wilkerson said the receiver should not be charged a fee to separate comingled records that should be segregated or identifiable. The receiver needs to have immediate access to the data. Mr. Baldwin agrees that a receiver does not want to be told by an affiliate that before the receiver can have access, there must be an expansive and expensive process to separate the comingled records. Ms. Slaymaker said fair and reasonable costs associated with the work of transferring the data are acceptable. Mr. Kennedy agreed that receivers should not have to pay to separate comingled data and records.

Mr. Cantilo said in a conventional way, the insurer’s data and records would be separated automatically and be immediately available to the receiver at no cost. The decision by the company to consolidate records with an affiliate may be economically advantageous to the company. He said he believes that the company derives the benefit from that comingling during the operating period, and it should not serve as justification for imposing on the receiver a cost that the receiver would not face if the data had not been comingled. He said he has had experiences where gaining access to comingled records was extremely expensive and time consuming and required legal proceedings.

Mr. Baldwin said we will consider some revisions to this section to address Florida’s concern and make sure it is more precise and reasonable.

g. **Model #450, Section 19(B)(15)**

Mr. Baldwin said the proposed amendments to this paragraph were added to address cooperation prior to triggering a guaranty association. The NOLHGA and the NCIGF offered technical edits in their comment, primarily to replace “covered” with “eligible for coverage.” Mr. Baldwin said he agrees that the technical edits are reasonable. Ms. Slaymaker and Ms. Wilkerson agreed.

3. **Exposed Amendments to Model #440 and Model #450**

Mr. Baldwin said NAIC staff and members of the Working Group will draft revisions to the amendments based on the discussion on this call. The revisions will be exposed for a 14-day public comment period beginning on the date that staff distributes the updated amendments to members, interested state insurance regulators, and interested parties.

Having no further business, the Receivership Law (E) Working Group adjourned.

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The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force met Dec. 17, 2020. The following Working Group members participated: Kevin Baldwin, Co-Chair (IL); Laura Lyon Slaymaker, Co-Chair (PA); Steve Uhlrynowycz (AR); Jack Hom (CA); Rolf Kaumann (CO); Jared Kosky (CT); Toma Wilkerson (FL); Robert Koppin (IA); Christopher Joyce (MA); Robert Wake (ME); James Gerber (MI); Shelley Forrest (MO); Justin Schrader (NE); James Kennedy (TX); and Melanie Anderson (WA).

1. **Exposed Amendments to Model #440 and Model #450**

Ms. Slaymaker said during its Oct. 29 meeting, the Working Group agreed to draft amendments to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). The amendments are intended to ensure continuity of essential services and functions by affiliates to an insurer in receivership. A small group of state insurance regulators—including Illinois, Pennsylvania, Maine, Michigan, Oklahoma and Texas—developed a first draft of amendments that focus on three sections of Model #440 and Model #450.

a. **Model #440, Section 5(A) Standards and Management of an Insurer Within an Insurance Holding Company**

Ms. Slaymaker said the proposed addition of Section 5(A)(1)(g) provides for a bond from the affiliate for the performance of services. The provision for the bond and the amount of the bond are at the commissioner’s discretion. Mr. Kaumann suggested including a drafting note to explain the intent of the bond as a performance bond.

Ms. Slaymaker said the proposed addition of Section 5(A)(1)(h) includes a definition of records and data that is similar to the definition on the *Insurer Receivership Model Act* (#555). The purpose of this section is to make it clear that the transaction must define records and data of the insurer as the property of the insurer, and the affiliate must provide access to the insurer to all of these records and data. The Working Group agreed the intent for electronic data is that it should be in a format that can be extracted from other data.

Mr. Kennedy said most issues with records and data that is not segregated relate to electronic data, rather than paper files. Regarding the use of information technology (IT) references, such as “silo” or “partition,” the Working Group suggested members’ IT staff could review the language. After discussion, the Working Group agreed to edit the first sentence to read, “All records and data of the insurer held by an affiliate are and remain the property of the insurer, are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation from all other persons’ records and data.”

Ms. Slaymaker said the proposed addition of Section 5(A)(1)(i) aims to define that premium and other funds of the insurer are the property of the insurer and should not be commingled. She said a receiver’s right to suspend rights of offset agreements during a receivership can be addressed through a review of guidance in the *Receiver’s Handbook for Insurance Company Insolvencies*.

Peter Gallanis (National Organization of Life and Health Guaranty Association—NOLHGA) summarized the joint comment letter from NOLHGA and the National Conference of Insurance Guaranty Funds (NCIGF) for the proposed new Section 5(A)(6) and Section 5(A)(7) (Attachment One-A1a). He said the direction of the draft language is right and that the comment letter proposes friendly amendments. After discussion, the Working Group agreed to accept NOLHGA and the NCIGF’s proposed edits, remove the phrase “and that the agreement or contract is governed by the law of this state” in the last paragraph, and renumber the paragraphs.

b. **Model #440, Section 11 Sanctions**

Ms. Slaymaker said the addition of Section 11(D) is similar to Section 5(A)(1)(g) but in this instance included a possible sanction the commissioner could consider if the commissioner determines that Section 5A of the Model #440 has been violated or if the agreement had not been properly reported and approved.
c. **Model #450, Section 19 Transactions Subject to Prior Notice—Notice Filing (Form D)**

Mr. Baldwin said the proposed amendments to Section 19B(6) include the same definition of records and data as proposed in Model #440 Section 5(A)(1)(h). The amendment expands upon the requirement that the affiliated agreement include language that defines records and data of the insurer. Mr. Baldwin instructed NAIC staff to make edits consistent with Model #440 Section 5(A)(1)(h).

Mr. Baldwin said the proposed amendments to Section 19B(7) address segregating records and data of the insurer. Mr. Baldwin instructed NAIC staff to make edits consistent with Model #440 Section 5(A)(1)(h).

Mr. Baldwin said the proposed amendments to Section 19B(10) were proposed by America’s Health Insurance Plans (AHIP). The proposal will be edited to include additional paragraphs added to Subsection B.

Mr. Baldwin said the proposed amendments to Section 19B(11) and 19B(11) refer to “supervision, seizure, conservation, or receivership” to account for the variations in states laws. Harold Horwich (Morgan Lewis & Bockius LLP) suggested the addition of “supervision” to this subsection would require edits to Section 19B(11)(a). The Working Group agreed to add the phrase “to the extent permitted by [law of the state]” to the end of Section 19B(11)(a).

Mr. Baldwin said the proposed amendments to Section 19B(11)(b) require that the agreement state records and data are provided in a usable format and at no cost. The intent of the amendments is to address issues that were raised where affiliates do not maintain or provide the insurer’s data in a format that is necessary to operate the insurer and be able to pay claims, as well as the issue that affiliates demand high fees to receive the insurer’s data. Mr. Horwich recommending adding “of the insurer” to the reference to records and data. The Working Group agreed.

Mr. Baldwin said the proposed amendments to Section 19B(11)(c) require that the agreement provides that the employees of the affiliate that have been essential to the operations of the insurer will be made available to the receiver to ensure the services continue to be provided.

Mr. Baldwin said the proposed addition of Section 19B(13) specifies that essential services will be provided for a specified time, which can be defined in the agreement. It also specifies that this is without regard to pre-receivership unpaid fees, but so long as the payment for post-receivership services are made.

Mr. Baldwin said the proposed amendments to Section 19B(14) include changes for consistency in terminology with other amendments and clarify that timely payment refers to payment for post-receivership services.

Mr. Baldwin said NOLHGA and the NCIGF proposed the addition of Section 19B(15), which he believes is within the scope and that it is intended that continuation of essential services extend to guaranty associations to perform their role in the policyholder protection scheme.

Mr. Gallanis said the direction of the changes proposed today are all intended to address the seamless uninterrupted protection of policyholders. In insolvencies where blocks of business are covered by guaranty associations, the intent of this proposed section is to clarify that the continuity provisions addressed also serve the objectives of the guaranty associations in protecting consumers. Mr. Kennedy asked if supervision, seizure or conservatorship should be included. Mr. Horwich said the guaranty funds need to be able to prepare for an eventual receivership.

Mr. Gallanis said in drafting this section, he focused on what guaranty associations do to service claims and transfer or assume blocks of business. He agreed with Mr. Horwich that guaranty funds work with receivers on analysis of company data and records, specifically policy files, in advance of the transition to the guaranty association. If there is a likelihood for receivership, the ability to do the analysis prior to guaranty associations being triggered is important to policyholder protection. Roger Schmelzer (NCIGF) said he agrees with Mr. Gallanis. He said it is important for guaranty funds to have the option to be able to look at digital information of a company that would likely be placed into receivership.

Mr. Kennedy said that as this is referring not just to guaranty funds currently providing coverage but that may be providing coverage on a receivership in the near future, he suggests moving the phrase “in furtherance of the cooperation between the receiver and the affected guaranty association(s) and subject to the receiver's authority over the insurer” to the beginning of the paragraph. After further discussion, the Working Group agreed to include the proposed Section 19B(15) with the suggested reorganization.
Mr. Baldwin said the draft amendments would be exposed for a 35-day public comment period ending Jan. 22, 2021. The comment period was later extended to Jan. 29, 2021 (Attachment One-A1b).

Having no further business, the Receivership Law (E) Working Group adjourned.
JOINT SUBMISSION TO RECEIVERSHIP LAW (E) WORKING GROUP
REVIEW AND CONSIDERATION OF EXPOSURE OF
DRAFT AMENDMENTS TO MODELS #440 & #450

December 16, 2020

NOLHGA and NCIGF provide the following comments in advance of the Working Group's review and consideration of the exposure of draft amendments to Models #440 and #450 ("Draft Amendments") on December 17. The Draft Amendments offer constructive solutions to address the issue of continuity in the provision of essential services by affiliates in the event of the receivership of an insurer. The following comments are intended to provide clarity on two points as you consider the exposure.

Model #440 Sections 5A(6)&(7)

We suggest merging the concepts in these two sections to further ensure consistency. Section 5A(6) refers to the "jurisdiction of the receivership court" while Section 5A(7) refers to the "jurisdiction of any supervision, seizure, conservatorship, or receivership proceedings against the insurer, and to the authority of any supervisor, conservator, rehabilitator, or liquidator...." We suggest combining these sections into a new Section 5A(6) as follows:

Any affiliate that is party to an agreement or contract pursuant to Subsection A(2)(d), shall be subject to the jurisdiction of any supervision, seizure, conservatorship, or receivership proceedings against the insurer, and to the authority of any supervisor, conservator, rehabilitator, or liquidator for the insurer appointed pursuant to [supervision and receivership acts] for the purpose of interpreting, enforcing, and overseeing the affiliate’s agreements, relationship, and dealings with the insurer, if the services provided by the affiliate to the insurer:

(a) are an integral part of the insurer’s operations, including but not limited to management, administrative, accounting, data processing, marketing, underwriting, claims handling, investment, or any other similar functions; or

(b) are essential to the insurer’s ability to fulfil its obligations under insurance policies.

Any agreement or contract pursuant to Subsection A(2)(d) for the provision of services described in (a) and (b) above must specify that the affiliate consents to the jurisdiction as set forth in this Section 5A(6), and that the agreement or contract is governed by the law of this state.
Model #450 Section 19B

To further advance the goals of the proposal, we suggest adding a new Section 19B(15) to address continuity of services in the event the insurer is placed in receivership and guaranty associations are triggered:

Specify that, if the insurer is placed into supervision, seizure, conservatorship, or receivership pursuant to [supervision and receivership acts], and portions of the insurer's policies or contracts are covered by one or more guaranty associations, the affiliate's commitments under Sections 19B(11)-(14) will extend to the guaranty association(s) providing such coverage, in furtherance of the cooperation between the receiver and the affected guaranty association(s) and subject to the receiver's authority over the insurer.

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We appreciate your consideration of these proposed changes, and we look forward to contributing to the Working Group's continued discussions. To that end, Peter Gallanis and Roger Schmelzer will be available to discuss these comments during the Working Group's call on December 17.

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INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

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Section 1. Definitions note

As used in this Act, the following terms shall have these meanings unless the context shall otherwise require:

A. “Affiliate.” An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

B. “Commissioner.” The term “commissioner” shall mean the insurance commissioner, the commissioner’s deputies, or the Insurance Department, as appropriate.

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

C. “Control.” The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by Section 4K that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

D. “Group-wide supervisor.” The regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the commissioner under Section 7.1 to have sufficient significant contacts with the internationally active insurance group.
Insurance Holding Company System Regulatory Act

E. "Group Capital Calculation instructions" means the group capital calculation instructions as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

F. “Insurance Holding Company System.” An “insurance holding company system” consists of two (2) or more affiliated persons, one or more of which is an insurer.

G. “Insurer.” The term “insurer” shall have the same meaning as set forth in Section [insert applicable section] of this Chapter, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

Drafting Note: References in this model act to “Chapter” are references to the entire state insurance code.

Drafting Note: States should consider applicability of this model act to fraternal societies and captives.

H. “Internationally active insurance group.” An insurance holding company system that (1) includes an insurer registered under Section 4; and (2) meets the following criteria: (a) premiums written in at least three countries, (b) the percentage of gross premiums written outside the United States is at least ten percent (10%) of the insurance holding company system’s total gross written premiums, and (c) based on a three-year rolling average, the total assets of the insurance holding company system are at least fifty billion dollars ($50,000,000,000) or the total gross written premiums of the insurance holding company system are at least ten billion dollars ($10,000,000,000).

I. “Enterprise Risk.” “Enterprise risk” shall mean any activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer’s Risk-Based Capital to fall into company action level as set forth in [insert cross reference to appropriate section of Risk-Based Capital (RBC) Model Act] or would cause the insurer to be in hazardous financial condition [insert cross reference to appropriate section of Model Regulation to define standards and commissioner’s authority over companies deemed to be in hazardous financial condition].

J. “NAIC” means the National Association of Insurance Commissioners.

K. “NAIC Liquidity Stress Test Framework.” The “NAIC Liquidity Stress Test Framework” is a separate NAIC publication which includes a history of the NAIC’s development of regulatory liquidity stress testing, the Scope Criteria applicable for a specific data year, and the Liquidity Stress Test instructions and reporting templates for a specific data year, such Scope Criteria, instructions and reporting template being as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

L. “Person.” A “person” is an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert, but shall not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property.

M. “Scope Criteria.” The “Scope Criteria,” as detailed in the NAIC Liquidity Stress Test Framework, are the designated exposure bases along with minimum magnitudes thereof for the specified data year, used to establish a preliminary list of insurers considered scoped into the NAIC Liquidity Stress Test Framework for that data year.

N. “Securityholder.” A “securityholder” of a specified person is one who owns any security of such person, including common stock, preferred stock, debt obligations and any other security convertible into or evidencing the right to acquire any of the foregoing.

O. “Subsidiary.” A “subsidiary” of a specified person is an affiliate controlled by such person directly or indirectly through one or more intermediaries.
P. “Voting Security.” The term “voting security” shall include any security convertible into or evidencing a right to acquire a voting security.

Section 2. Subsidiaries of Insurers

A. Authorization. A domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries. The subsidiaries may conduct any kind of business or businesses and their authority to do so shall not be limited by reason of the fact that they are subsidiaries of a domestic insurer.

Drafting Note: This bill neither expressly authorizes noninsurance subsidiaries nor restricts subsidiaries to insurance related activities. It is believed that this is a policy decision which should be made by each individual state. Attached as an appendix are alternative provisions which would authorize the formation or acquisition of subsidiaries to engage in diversified business activity.

B. Additional Investment Authority. In addition to investments in common stock, preferred stock, debt obligations and other securities permitted under all other sections of this Chapter, a domestic insurer may also:

(1) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts which do not exceed the lesser of ten percent (10%) of the insurer’s assets or fifty percent (50%) of the insurer’s surplus as regards policyholders, provided that after such investments, the insurer’s surplus as regards policyholders will be reasonable in relation to the insurer’s outstanding liabilities and adequate to meet its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries and health maintenance organizations shall be excluded, and there shall be included:

(a) Total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities, and

(b) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities; and all contributions to the capital or surplus of a subsidiary subsequent to its acquisition or formation;

Drafting Note: When considering whether to amend its Holding Company Act to exempt health maintenance organizations and other similar entities from certain investment limitations, a state should consider whether the solvency and general operations of the entities are regulated by the insurance department. In addition to, or in place of, the term “health maintenance organizations” in Paragraph (1) above, a state may include any other entity which provides or arranges for the financing or provision of health care services or coverage over which the commissioner possesses financial solvency and regulatory oversight authority.

(2) Invest any amount in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer provided that each subsidiary agrees to limit its investments in any asset so that such investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in Paragraph (1) or in Sections [insert applicable section] through [insert applicable section] of this Chapter applicable to the insurer. For the purpose of this paragraph, “the total investment of the insurer” shall include:

(a) Any direct investment by the insurer in an asset, and

(b) The insurer’s proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary’s investment by the percentage of the ownership of the subsidiary;
(3) With the approval of the commissioner, invest any greater amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries; provided that after the investment the insurer’s surplus as regards policyholders will be reasonable in relation to the insurer’s outstanding liabilities and adequate to its financial needs.

C. Exemption from Investment Restrictions. Investments in common stock, preferred stock, debt obligations or other securities of subsidiaries made pursuant to Subsection B shall not be subject to any of the otherwise applicable restrictions or prohibitions contained in this Chapter applicable to such investments of insurers [except the following: ].

Drafting Note: The last phrase is optional in those states having certain special qualitative limitations, such as prohibitions on investments in stock of mining companies, which the state may wish to retain as a matter of public policy.

D. Qualification of Investment; When Determined. Whether any investment made pursuant to Subsection B meets the applicable requirements of that subsection is to be determined before the investment is made, by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested, not including dividends.

E. Cessation of Control. If an insurer ceases to control a subsidiary, it shall dispose of any investment therein made pursuant to this section within three (3) years from the time of the cessation of control or within such further time as the commissioner may prescribe, unless at any time after the investment shall have been made, the investment shall have met the requirements for investment under any other section of this Chapter, and the insurer has so notified the commissioner.

Section 3. Acquisition of Control of or Merger with Domestic Insurer

A. Filing Requirements.

(1) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would, directly or indirectly (or by conversion or by exercise of any right to acquire) be in control of the insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time the offer, request or invitation is made or the agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, such person has filed with the commissioner and has sent to the insurer, a statement containing the information required by this section and the offer, request, invitation, agreement or acquisition has been approved by the commissioner in the manner prescribed in this Act.

(2) For purposes of this section, any controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least 30 days prior to the cessation of control. The commissioner shall determine those instances in which the party(ies) seeking to divest or to acquire a controlling interest in an insurer, will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the commissioner, in his or her discretion determines that confidential treatment will interfere with enforcement of this section. If the statement referred to in Paragraph (1) is otherwise filed, this paragraph shall not apply.

(3) With respect to a transaction subject to this section, the acquiring person must also file a pre-acquisition notification with the commissioner, which shall contain the information set forth in Section 3.1C(1). A failure to file the notification may be subject to penalties specified in Section 3.1E(3).
(4) For purposes of this section a domestic insurer shall include any person controlling a domestic insurer unless the person, as determined by the commissioner, is either directly or through its affiliates primarily engaged in business other than the business of insurance. For the purposes of this section, “person” shall not include any securities broker holding, in the usual and customary broker’s function, less than twenty percent (20%) of the voting securities of an insurance company or of any person which controls an insurance company.

B. Content of Statement. The statement to be filed with the commissioner shall be made under oath or affirmation and shall contain the following:

(1) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in Subsection A is to be effected (hereinafter called the “acquiring party”), and

(a) If the person is an individual, his or her principal occupation and all offices and positions held during the past five (5) years, and any conviction of crimes other than minor traffic violations during the past ten (10) years;

(b) If the person is not an individual, a report of the nature of its business operations during the past five (5) years or for the lesser period as the person and any predecessors shall have been in existence; an informative description of the business intended to be done by the person and the person’s subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of the person, or who perform or will perform functions appropriate to such positions. The list shall include for each individual the information required by Subparagraph (a) of this paragraph;

(2) The source, nature and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction where funds were or are to be obtained for any such purpose (including any pledge of the insurer’s stock, or the stock of any of its subsidiaries or controlling affiliates), and the identity of persons furnishing consideration; provided, however, that where a source of consideration is a loan made in the lender’s ordinary course of business, the identity of the lender shall remain confidential, if the person filing the statement so requests;

(3) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five (5) fiscal years of each acquiring party (or for such lesser period as the acquiring party and any predecessors shall have been in existence), and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement;

(4) Any plans or proposals which each acquiring party may have to liquidate the insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management;

(5) The number of shares of any security referred to in Subsection A which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement or acquisition referred to in Subsection A, and a statement as to the method by which the fairness of the proposal was arrived at;

(6) The amount of each class of any security referred to in Subsection A which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(7) A full description of any contracts, arrangements or understandings with respect to any security referred to in Subsection A in which any acquiring party is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. The description shall identify the persons with whom the contracts, arrangements or understandings have been entered into;
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(8) A description of the purchase of any security referred to in Subsection A during the twelve (12) calendar months preceding the filing of the statement by any acquiring party, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid;

(9) A description of any recommendations to purchase any security referred to in Subsection A made during the twelve (12) calendar months preceding the filing of the statement by any acquiring party, or by anyone based upon interviews or at the suggestion of the acquiring party;

(10) Copies of all tender offers for, requests, or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in Subsection A, and (if distributed) of additional soliciting material relating to them;

(11) The term of any agreement, contract or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in Subsection A for tender, and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto;

Drafting Note: An insurer required to file information pursuant to sub-sections 3B(12) and 3B(13) may satisfy the requirement by providing the commissioner with the most recently filed parent corporation reports that have been filed with the SEC, if appropriate.

(12) An agreement by the person required to file the statement referred to in Subsection A that it will provide the annual report, specified in Section 4L(1), for so long as control exists;

(13) An acknowledgement by the person required to file the statement referred to in Subsection A that the person and all subsidiaries within its control in the insurance holding company system will provide information to the commissioner upon request as necessary to evaluate enterprise risk to the insurer; and

(14) Such additional information as the commissioner may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

If the person required to file the statement referred to in Subsection A is a partnership, limited partnership, syndicate or other group, the commissioner may require that the information called for by Paragraphs (1) through (14) shall be given with respect to each partner of the partnership or member of the syndicate or group, and each person who controls the partner or member. If any partner, member or person is a corporation or the person required to file the statement referred to in Subsection A is a corporation, the commissioner may require that the information called for by Paragraphs (1) through (14) shall be given with respect to the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent (10%) of the outstanding voting securities of the corporation.

If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to the insurer pursuant to this section, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the commissioner and sent to the insurer within two (2) business days after the person learns of the change.

C. Alternative Filing Materials.

If any offer, request, invitation, agreement or acquisition referred to in Subsection A is proposed to be made by means of a registration statement under the Securities Act of 1933 or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in Subsection A may utilize the documents in furnishing the information called for by that statement.
D. Approval by Commissioner: Hearings.

(1) The commissioner shall approve any merger or other acquisition of control referred to in Subsection A unless, after a public hearing, the commissioner finds that:

(a) After the change of control, the domestic insurer referred to in Subsection A would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(b) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly. In applying the competitive standard in this subparagraph:

(i) The informational requirements of Section 3.1C(1) and the standards of Section 3.1D(2) shall apply;

(ii) The merger or other acquisition shall not be disapproved if the commissioner finds that any of the situations meeting the criteria provided by Section 3.1D(3) exist; and

(iii) The commissioner may condition the approval of the merger or other acquisition on the removal of the basis of disapproval within a specified period of time;

(c) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders;

(d) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(e) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control; or

(f) The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

(2) The public hearing referred to in Paragraph (1) shall be held within thirty (30) days after the statement required by Subsection A is filed, and at least twenty (20) days notice shall be given by the commissioner to the person filing the statement. Not less than seven (7) days notice of the public hearing shall be given by the person filing the statement to the insurer and to such other persons as may be designated by the commissioner. The commissioner shall make a determination within the sixty (60) day period preceding the effective date of the proposed transaction. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in the [insert title] Court of this state. All discovery proceedings shall be concluded not later than three (3) days prior to the commencement of the public hearing.

(3) If the proposed acquisition of control will require the approval of more than one commissioner, the public hearing referred to in Paragraph (2) may be held on a consolidated basis upon request of the person filing the statement referred to in Subsection A. Such person shall file the statement referred to in Subsection A with the National Association of Insurance Commissioners (NAIC) within five (5) days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing, and shall provide notice to the applicant of the opt-out within ten (10) days of the receipt of the statement referred to in Subsection A. A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the commissioners of the states in which the insurers are domiciled. Such commissioners shall hear and receive evidence. A
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commissioner may attend such hearing, in person or by telecommunication.

(4) In connection with a change of control of a domestic insurer, any determination by the commissioner that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws and regulations of this state shall be made not later than sixty (60) days after the date of notification of the change in control submitted pursuant to Section 3A(1) of this Act.

(5) The commissioner may retain at the acquiring person’s expense any attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner’s staff as may be reasonably necessary to assist the commissioner in reviewing the proposed acquisition of control.

E. Exemptions. The provisions of this section shall not apply to:

(1) [Any transaction which is subject to the provisions of Sections [insert applicable section] and [insert applicable section] of the laws of this state, dealing with the merger or consolidation of two or more insurers].

Drafting Note: Optional for use in those states where existing law adequately governs standards and procedures for the merger or consolidation of two or more insurers.

(2) Any offer, request, invitation, agreement or acquisition which the commissioner by order shall exempt as not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer, or as otherwise not comprehended within the purposes of this section.

F. Violations. The following shall be violations of this section:

(1) The failure to file any statement, amendment or other material required to be filed pursuant to Subsection A or B; or

(2) The effectuation or any attempt to effectuate an acquisition of control of, divestiture of, or merger with, a domestic insurer unless the commissioner has given approval.

G. Jurisdiction, Consent to Service of Process. The courts of this state are hereby vested with jurisdiction over every person not resident, domiciled or authorized to do business in this state who files a statement with the commissioner under this section, and overall actions involving such person arising out of violations of this section, and each such person shall be deemed to have performed acts equivalent to and constituting an appointment by the person of the commissioner to be his true and lawful attorney upon whom may be served all lawful process in any action, suit or proceeding arising out of violations of this section. Copies of all lawful process shall be served on the commissioner and transmitted by registered or certified mail by the commissioner to the person at his last known address.

Section 3.1 Acquisitions Involving Insurers Not Otherwise Covered

A. Definitions. The following definitions shall apply for the purposes of this section only:

(1) “Acquisition” means any agreement, arrangement or activity the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes but is not limited to the acquisition of voting securities, the acquisition of assets, bulk reinsurance and mergers.

(2) An “involved insurer” includes an insurer which either acquires or is acquired, is affiliated with an acquirer or acquired, or is the result of a merger.

B. Scope

(1) Except as exempted in Paragraph (2) of this subsection, this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this state.
This section shall not apply to the following:

(a) A purchase of securities solely for investment purposes so long as the securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this state. If a purchase of securities results in a presumption of control under Section 1C, it is not solely for investment purposes unless the commissioner of the insurer’s state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and the disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the commissioner of this state;

(b) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if pre-acquisition notification is filed with the commissioner in accordance with Section 3.1C(1) thirty (30) days prior to the proposed effective date of the acquisition. However, such pre-acquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by any other subparagraph of Section 3.1B(2);

(c) The acquisition of already affiliated persons;

(d) An acquisition if, as an immediate result of the acquisition,

   (i) In no market would the combined market share of the involved insurers exceed five percent (5%) of the total market,

   (ii) There would be no increase in any market share, or

   (iii) In no market would

      (I) The combined market share of the involved insurers exceeds twelve percent (12%) of the total market, and

      (II) The market share increase by more than two percent (2%) of the total market.

For the purpose of this Paragraph (2)(d), a market means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state;

(e) An acquisition for which a pre-acquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business;

(f) An acquisition of an insurer whose domiciliary commissioner affirmatively finds that the insurer is in failing condition; there is a lack of feasible alternative to improving such condition; the public benefits of improving the insurer’s condition through the acquisition exceed the public benefits that would arise from not lessening competition; and the findings are communicated by the domiciliary commissioner to the commissioner of this state.

C. Pre-acquisition Notification; Waiting Period. An acquisition covered by Section 3.1B may be subject to an order pursuant to Section 3.1E unless the acquiring person files a pre-acquisition notification and the waiting period has expired. The acquired person may file a pre-acquisition notification. The commissioner shall give confidential treatment to information submitted under this subsection in the same manner as provided in Section 8 of this Act.

(1) The pre-acquisition notification shall be in such form and contain such information as prescribed by the National Association of Insurance Commissioners (NAIC) relating to those markets which, under Section 3.1B(2)(d), cause the acquisition not to be exempted from the provisions of this
section. The commissioner may require such additional material and information as deemed necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard of Section 3.1D. The required information may include an opinion of an economist as to the competitive impact of the acquisition in this state accompanied by a summary of the education and experience of such person indicating his or her ability to render an informed opinion.

(2) The waiting period required shall begin on the date of receipt of the commissioner of a pre-acquisition notification and shall end on the earlier of the thirtieth day after the date of receipt, or termination of the waiting period by the commissioner. Prior to the end of the waiting period, the commissioner on a one-time basis may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period shall end on the earlier of the thirtieth day after receipt of the additional information by the commissioner or termination of the waiting period by the commissioner.

D. Competitive Standard

(1) The commissioner may enter an order under Section 3.1E(1) with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly or if the insurer fails to file adequate information in compliance with Section 3.1C.

(2) In determining whether a proposed acquisition would violate the competitive standard of Paragraph (1) of this subsection, the commissioner shall consider the following:

(a) Any acquisition covered under Section 3.1B involving two (2) or more insurers competing in the same market is *prima facie* evidence of violation of the competitive standards.

(i) If the market is highly concentrated and the involved insurers possess the following shares of the market:

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Shares</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>4%</td>
</tr>
<tr>
<td>B</td>
<td>4% or more</td>
</tr>
<tr>
<td>A</td>
<td>10%</td>
</tr>
<tr>
<td>B</td>
<td>2% or more</td>
</tr>
<tr>
<td>A</td>
<td>15%</td>
</tr>
<tr>
<td>B</td>
<td>1% or more</td>
</tr>
</tbody>
</table>

(ii) Or, if the market is not highly concentrated and the involved insurers possess the following shares of the market:

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Shares</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>5%</td>
</tr>
<tr>
<td>B</td>
<td>5% or more</td>
</tr>
<tr>
<td>A</td>
<td>10%</td>
</tr>
<tr>
<td>B</td>
<td>4% or more</td>
</tr>
<tr>
<td>A</td>
<td>15%</td>
</tr>
<tr>
<td>B</td>
<td>3% or more</td>
</tr>
<tr>
<td>A</td>
<td>19%</td>
</tr>
<tr>
<td>B</td>
<td>1% or more</td>
</tr>
</tbody>
</table>

A highly concentrated market is one in which the share of the four (4) largest insurers is seventy-five percent (75%) or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two (2) insurers are involved, exceeding the total of the two columns in the table is *prima facie* evidence of violation of the competitive standard in Paragraph (1) of this subsection. For the purpose of this item, the insurer with the largest share of the market shall be deemed to be Insurer A.
(b) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two (2) largest to the eight (8) largest, has increased by seven percent (7%) or more of the market over a period of time extending from any base year five (5) to ten (10) years prior to the acquisition up to the time of the acquisition. Any acquisition or merger covered under Section 3.1B involving two (2) or more insurers competing in the same market is prima facie evidence of violation of the competitive standard in Paragraph (1) of this subsection if:

(i) There is a significant trend toward increased concentration in the market;

(ii) One of the insurers involved is one of the insurers in a grouping of large insurers showing the requisite increase in the market share; and

(iii) Another involved insurer’s market is two percent (2%) or more.

c) For the purposes of Section 3.1D(2):

(i) The term “insurer” includes any company or group of companies under common management, ownership or control;

(ii) The term “market” means the relevant product and geographical markets. In determining the relevant product and geographical markets, the commissioner shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the NAIC and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this state, and the relevant geographical market is assumed to be this state;

(iii) The burden of showing prima facie evidence of violation of the competitive standard rests upon the commissioner.

d) Even though an acquisition is not prima facie violative of the competitive standard under Paragraphs (2)(a) and (2)(b) of this subsection, the commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima facie violative of the competitive standard under Paragraphs (2)(a) and (2)(b) of this subsection, a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this subparagraph include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry and exit into the market.

(3) An order may not be entered under Section 3.1E(1) if:

(a) The acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or

(b) The acquisition will substantially increase the availability of insurance, and the public benefits of the increase exceed the public benefits which would arise from not lessening competition.

E. Orders and Penalties

(1) If an acquisition violates the standards of this section, the commissioner may enter an order:
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(i) Requiring an involved insurer to cease and desist from doing business in this state with respect to the line or lines of insurance involved in the violation; or

(ii) Denying the application of an acquired or acquiring insurer for a license to do business in this state.

(b) Such an order shall not be entered unless:

(i) There is a hearing;

(ii) Notice of the hearing is issued prior to the end of the waiting period and not less than fifteen (15) days prior to the hearing; and

(iii) The hearing is concluded and the order is issued no later than sixty (60) days after the date of the filing of the pre-acquisition notification with the commissioner.

Every order shall be accompanied by a written decision of the commissioner setting forth findings of fact and conclusions of law.

(c) An order pursuant to this paragraph shall not apply if the acquisition is not consummated.

(2) Any person who violates a cease and desist order of the commissioner under Paragraph (1) and while the order is in effect may, after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to one or more of the following:

(a) A monetary penalty of not more than $10,000 for every day of violation; or

(b) Suspension or revocation of the person’s license.

(3) Any insurer or other person who fails to make any filing required by this section, and who also fails to demonstrate a good faith effort to comply with any filing requirement, shall be subject to a fine of not more than $50,000.

F. Inapplicable Provisions. Sections 10B, 10C, and 12 do not apply to acquisitions covered under Section 3.1B.

Section 4. Registration of Insurers

A. Registration. Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in:

(1) Section 4;

(2) Section 5A(1), 5B, 5D; and

(3) Either Section 5A(2) or a provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen (15) days after the end of the month in which it learns of each change or addition.

Any insurer which is subject to registration under this section shall register within fifteen (15) days after it becomes subject to registration, and annually thereafter by [insert date] of each year for the previous calendar year, unless the commissioner for good cause shown extends the time for registration, and then within the extended time. The commissioner may require any insurer authorized to do business in the state which is a member of an insurance holding company system,
and which is not subject to registration under this section, to furnish a copy of the registration statement, the summary specified in Section 4C or other information filed by the insurance company with the insurance regulatory authority of its domiciliary jurisdiction.

B. Information and Form Required. Every insurer subject to registration shall file the registration statement with the commissioner on a form and in a format prescribed by the NAIC, which shall contain the following current information:

(1) The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer;

(2) The identity and relationship of every member of the insurance holding company system;

(3) The following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the insurer and its affiliates:

(a) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(b) Purchases, sales or exchange of assets;

(c) Transactions not in the ordinary course of business;

(d) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer’s assets to liability, other than insurance contracts entered into in the ordinary course of the insurer’s business;

(e) All management agreements, service contracts and all cost-sharing arrangements;

(f) Reinsurance agreements;

(g) Dividends and other distributions to shareholders; and

(h) Consolidated tax allocation agreements;

(4) Any pledge of the insurer’s stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(5) If requested by the commissioner, the insurer shall include financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include but are not limited to annual audited financial statements filed with the U.S. Securities and Exchange Commission (SEC) pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this paragraph may satisfy the request by providing the commissioner with the most recently filed parent corporation financial statements that have been filed with the SEC;

(6) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner;

Drafting Note: Neither option below is intended to modify applicable state insurance and/or corporate law requirements.

(7) Statements that the insurer’s board of directors oversees corporate governance and internal controls and that the insurer’s officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures; and
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Alternative Section 4B(7):

(7) Statements that the insurer’s board of directors is responsible for and oversees corporate governance and internal controls and that the insurer’s officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures; and

(8) Any other information required by the commissioner by rule or regulation.

C. Summary of Changes to Registration Statement. All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

D. Materiality. No information need be disclosed on the registration statement filed pursuant to Subsection B if the information is not material for the purposes of this section. Unless the commissioner by rule, regulation or order provides otherwise; sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees involving one-half of one percent (.5%) or less of an insurer’s admitted assets as of the 31st day of December next preceding shall not be deemed material for purposes of this section. The definition of materiality provided in this subsection shall not apply for purposes of the Group Capital Calculation or the Liquidity Stress Test Framework.

E. Reporting of Dividends to Shareholders. Subject to Section 5B, each registered insurer shall report to the commissioner all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof.

F. Information of Insurers. Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where the information is reasonably necessary to enable the insurer to comply with the provisions of this Act.

G. Termination of Registration. The commissioner shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

H. Consolidated Filing. The commissioner may require or allow two (2) or more affiliated insurers subject to registration to file a consolidated registration statement.

I. Alternative Registration. The commissioner may allow an insurer which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under Subsection A and to file all information and material required to be filed under this section.

J. Exemptions. The provisions of this section shall not apply to any insurer, information or transaction if and to the extent that the commissioner by rule, regulation or order shall exempt the same from the provisions of this section.

K. Disclaimer. Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or a disclaimer may be filed by the insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the commissioner, within thirty (30) days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer has been granted by the commissioner, or if the disclaimer is deemed to have been approved.
L. Enterprise Risk Filings.

(1) The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person’s knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners;

(2) Group Capital Calculation. Except as provided below, the ultimate controlling person of every insurer subject to registration shall concurrently file with the registration an annual group capital calculation as directed by the lead state commissioner. The report shall be completed in accordance with the NAIC Group Capital Calculation Instructions, which may permit the lead state commissioner to allow a controlling person that is not the ultimate controlling person to file the group capital calculation. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the commissioner in accordance with the procedures within the Financial Analysis Handbook adopted by the NAIC. Insurance holding company systems described below are exempt from filing the group capital calculation:

(a) An insurance holding company system that has only one insurer within its holding company structure, that only writes business [and is only licensed] in its domestic state, and assumes no business from any other insurer;

(b) An insurance holding company system that is required to perform a group capital calculation specified by the United States Federal Reserve Board. The lead state commissioner shall request the calculation from the Federal Reserve Board under the terms of information sharing agreements in effect. If the Federal Reserve Board cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the group capital calculation filing;

(c) An insurance holding company system whose non-U.S. group-wide supervisor is located within a Reciprocal Jurisdiction as described in [insert cross-reference to appropriate section of Credit for Reinsurance Law] that recognizes the U.S. state regulatory approach to group supervision and group capital;

(d) An insurance holding company system:

(i) That provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program, either directly or indirectly through the group-wide supervisor, who has determined such information is satisfactory to allow the lead state to comply with the NAIC group supervision approach, as detailed in the NAIC Financial Analysis Handbook, and

(ii) Whose non-U.S. group-wide supervisor that is not in a Reciprocal Jurisdiction recognizes and accepts, as specified by the commissioner in regulation, the group capital calculation as the world-wide group capital assessment for U.S. insurance groups who operate in that jurisdiction.

Drafting Note: On September 22, 2017, the United States and the European Union (EU) entered into the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance.” A similar agreement with the United Kingdom (UK) was signed on December 18, 2018. Both agreements are considered to be a “covered agreement” entered into pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that addresses the U.S. state regulatory approach to group supervision and group capital, and provides that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the commissioner or the commissioner of the domiciliary state and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group. Under the revised Credit for Reinsurance Models, not only are jurisdictions that are subject to the EU and UK Covered Agreements treated as Reciprocal Jurisdictions, but any other Qualified Jurisdiction can also qualify as Reciprocal Jurisdiction if they provide written confirmation that they recognize and accept the U.S. state regulatory approach to group supervision and group capital.
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Drafting Note: The phrase “Recognizes and accepts” does not require the non-U.S. group-wide supervisor to require the U.S. insurance groups to actually file the group capital calculation with the non-U.S. supervisor but rather does not apply its own version of a group capital filing to U.S. insurance groups.

(e) Notwithstanding the provisions of Sections 4L(2)(c) and 4L(2)(d), a lead state commissioner shall require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace.

(f) Notwithstanding the exemptions from filing the group capital calculation stated in Section 4L(2)(a) through Section 4L(2)(d), the lead state commissioner has the discretion to exempt the ultimate controlling person from filing the annual group capital calculation or to accept a limited group capital filing or report in accordance with criteria as specified by the commissioner in regulation.

(g) If the lead state commissioner determines that an insurance holding company system no longer meets one or more of the requirements for an exemption from filing the group capital calculation under this section, the insurance holding company system shall file the group capital calculation at the next annual filing date unless given an extension by the lead state commissioner based on reasonable grounds shown.

(3) Liquidity Stress Test. The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC Liquidity Stress Test Framework shall file the results of a specific year’s Liquidity Stress Test. The filing shall be made to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners:

(a) The NAIC Liquidity Stress Test Framework includes Scope Criteria applicable to a specific data year. These Scope Criteria are reviewed at least annually by the Financial Stability Task Force or its successor. Any change to the NAIC Liquidity Stress Test Framework or to the data year for which the Scope Criteria are to be measured shall be effective on January 1 of the year following the calendar year when such changes are adopted. Insurers meeting at least one threshold of the Scope Criteria are considered scoped into the NAIC Liquidity Stress Test Framework for the specified data year unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should not be scoped into the Framework for that data year. Similarly, insurers that do not trigger at least one threshold of the Scope Criteria are considered scoped out of the NAIC Liquidity Stress Test Framework for that data year.

(i) Regulators wish to avoid having insurers scoped in and out of the NAIC Liquidity Stress Test Framework on a frequent basis. The lead state insurance commissioner, in consultation with the Financial Stability Task Force or its successor, will assess this concern as part of the determination for an insurer.

(b) The performance of, and filing of the results from, a specific year’s Liquidity Stress Test shall comply with the NAIC Liquidity Stress Test Framework’s instructions and reporting templates for that year and any lead state insurance commissioner determinations, in conjunction with the Financial Stability Task Force or its successor, provided within the Framework.

Drafting Note: The delay included in the change to the NAIC Liquidity Stress Test Framework or to the data year for which the Scope Criteria are to be measured being effective on January 1 of the year following the calendar year when such changes are adopted is present to: 1) allow sufficient time for states needing to adopt by rule the NAIC Liquidity Stress Test Framework for a given data year and 2) to ensure scoped in insurers have adequate time to comply with the requirements for a given data year.
M. Violations. The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required by this section within the time specified for filing shall be a violation of this section.

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

A. Transactions Within an Insurance Holding Company System

(1) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(a) The terms shall be fair and reasonable;

(b) Agreements for cost sharing services and management shall include such provisions as required by rule and regulation issued by the commissioner;

(c) Charges or fees for services performed shall be reasonable;

(d) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(e) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties;

(f) The insurer’s surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer’s outstanding liabilities and adequate to meet its financial needs;

(g) The insurer shall require the affiliated person(s) to obtain and maintain a bond for the protection of the insurer for the duration of the contract or agreement as required by the commissioner at any time. The bond amount should be no less than the amount specified by the commissioner;

Drafting Note: The intent of the bond is to ensure the affiliated services provided under the contract are fulfilled, which may be referred to as a “performance bond”.

(h) All records and data of the insurer held by an affiliate are and remain the property of the insurer, are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation from all other persons’ records and data. This includes all records and data that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate. At the request of the insurer, the affiliate shall make all records and data related to the insurer available for inspection, and shall provide the insurer with any login instructions, passwords, software or other information necessary to obtain access to the records and data. The affiliate shall provide a waiver of any landlord lien or other encumbrance to giving the insurer access to all records and data in the event of the affiliate’s default under a lease or other agreement; and,

(i) Premiums or other funds belonging to the insurer that are collected by or held by an affiliate are the exclusive property of the insurer and are subject to the control of the insurer. An affiliate shall not commingle any premiums or other funds belonging to the insurer with any other accounts.

(2) The following transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed...
pursuant to this section, which are subject to any materiality standards contained in subparagraphs (a) through (g), may not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into the transaction at least thirty (30) days prior thereto, or such shorter period as the commissioner may permit, and the commissioner has not disapproved it within that period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within thirty (30) days after a termination of a previously filed agreement, to the commissioner for determination of the type of filing required, if any.

(a) Sales, purchases, exchanges, loans, extensions of credit, or investments, provided the transactions are equal to or exceed:

(i) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer’s admitted assets or twenty-five percent (25%) of surplus as regards policyholders as of the 31st day of December next preceding;

(ii) With respect to life insurers, three percent (3%) of the insurer’s admitted assets as of the 31st day of December next preceding;

(b) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit provided the transactions are equal to or exceed:

(i) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer’s admitted assets or twenty-five percent (25%) of surplus as regards policyholders as of the 31st day of December next preceding;

(ii) With respect to life insurers, three percent (3%) of the insurer’s admitted assets as of the 31st day of December next preceding;

(c) Reinsurance agreements or modifications thereto, including:

(i) All reinsurance pooling agreements;

(ii) Agreements in which the reinsurance premium or a change in the insurer’s liabilities, or the projected reinsurance premium or a change in the insurer’s liabilities in any of the next three years, equals or exceeds five percent (5%) of the insurer’s surplus as regards policyholders, as of the 31st day of December next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a non-affiliate, if an agreement or understanding exists between the insurer and non-affiliate that any portion of the assets will be transferred to one or more affiliates of the insurer;

(d) All management agreements, service contracts, tax allocation agreements, guarantees and all cost-sharing arrangements;

(e) Guarantees when made by a domestic insurer; provided, however, that a guarantee which is quantifiable as to amount is not subject to the notice requirements of this paragraph unless it exceeds the lesser of one-half of one percent (.5%) of the insurer’s admitted assets or ten percent (10%) of surplus as regards policyholders as of the 31st day of December next preceding. Further, all guarantees which are not quantifiable as to amount are subject to the notice requirements of this paragraph;

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

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

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

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

(3) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the commissioner determines that separate transactions were entered into over any twelve-month period for that purpose, the commissioner may exercise his or her authority under Section 11.

(4) The commissioner, in reviewing transactions pursuant to Subsection A(2), shall consider whether the transactions comply with the standards set forth in Subsection A(1) and whether they may adversely affect the interests of policyholders.

(5) The commissioner shall be notified within thirty (30) days of any investment of the domestic insurer in any one corporation if the total investment in the corporation by the insurance holding company system exceeds ten percent (10%) of the corporation’s voting securities.

(6) Supervision, seizure, conservatorship, or receivership proceedings.

(a) Any affiliate that is party to an agreement or contract pursuant to Subsection A(2)(d), shall be subject to the jurisdiction of any supervision, seizure, conservatorship, or receivership proceedings against the insurer, and to the authority of any supervisor, conservator, rehabilitator, or liquidator for the insurer appointed pursuant to [supervision and receivership acts] for the purpose of interpreting, enforcing, and overseeing the affiliate’s agreements, relationship, and dealings with the insurer, if the services provided by the affiliate to the insurer:

(i) are an integral part of the insurer’s operations, including but not limited to management, administrative, accounting, data processing, marketing, underwriting, claims handling, investment, or any other similar functions; or

(ii) are essential to the insurer’s ability to fulfil its obligations under insurance policies.

(b) Any agreement or contract pursuant to Subsection A(2)(d) for the provision of services described in (i) and (ii) above must specify that the affiliate consents to the jurisdiction as set forth in this Section 5A(6).

B. Dividends and other Distributions

No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until thirty (30) days after the commissioner has received notice of the declaration thereof and has not within that period disapproved the payment, or until the commissioner has approved the payment within the thirty-day period.
For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve (12) months exceeds the lesser of:

1. Ten percent (10%) of the insurer’s surplus as regards policyholders as of the 31st day of December next preceding; or

2. The net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the twelve-month period ending the 31st day of December next preceding, but shall not include pro rata distributions of any class of the insurer’s own securities.

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

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

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

C. Management of Domestic Insurers Subject To Registration.

1. Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this Act.

2. Nothing in this section shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property or services with one or more other persons under arrangements meeting the standards of Section 5A(1).

3. Not less than one-third of the directors of a domestic insurer, and not less than one-third of the members of each committee of the board of directors of any domestic insurer shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one such person must be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof.

4. The board of directors of a domestic insurer shall establish one or more committees comprised solely of directors who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee or committees shall have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer and recommending to the board of directors the selection and compensation of the principal officers.

5. The provisions of Paragraphs (3) and (4) shall not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation, has a board of directors and committees thereof that meet the requirements of Paragraphs (3) and (4) with respect to such controlling entity.
An insurer may make application to the commissioner for a waiver from the requirements of this subsection, if the insurer’s annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, is less than $300,000,000. An insurer may also make application to the commissioner for a waiver from the requirements of this subsection based upon unique circumstances. The commissioner may consider various factors including, but not limited to, the type of business entity, volume of business written, availability of qualified board members, or the ownership or organizational structure of the entity.

D. Adequacy of Surplus. For purposes of this Act, in determining whether an insurer’s surplus as regards policyholders is reasonable in relation to the insurer’s outstanding liabilities and adequate to meet its financial needs, the following factors, among others, shall be considered:

1. The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

2. The extent to which the insurer’s business is diversified among several lines of insurance;

3. The number and size of risks insured in each line of business;

4. The extent of the geographical dispersion of the insurer’s insured risks;

5. The nature and extent of the insurer’s reinsurance program;

6. The quality, diversification and liquidity of the insurer’s investment portfolio;

7. The recent past and projected future trend in the size of the insurer’s investment portfolio;

8. The surplus as regards policyholders maintained by other comparable insurers;

9. The adequacy of the insurer’s reserves; and

10. The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the judgment of the commissioner the investment so warrants.

Section 6. Examination

A. Power of Commissioner. Subject to the limitation contained in this section and in addition to the powers which the commissioner has under Sections [insert applicable sections] relating to the examination of insurers, the commissioner shall have the power to examine any insurer registered under Section 4 and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

B. Access to Books and Records.

1. The commissioner may order any insurer registered under Section 4 to produce such records, books, or other information papers in the possession of the insurer or its affiliates as are reasonably necessary to determine compliance with this Chapter.

2. To determine compliance with this Chapter, the commissioner may order any insurer registered under Section 4 to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations, or other method. In the event the insurer cannot obtain the information requested by the commissioner, the insurer shall provide the commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of information. Whenever it appears to the commissioner that the detailed explanation is without merit, the commissioner...
may require, after notice and hearing, the insurer to pay a penalty of $[insert amount] for each
day’s delay, or may suspend or revoke the insurer’s license.

C. Use of Consultants. The commissioner may retain at the registered insurer’s expense such attorneys,
actuaries, accountants and other experts not otherwise a part of the commissioner’s staff as shall be
reasonably necessary to assist in the conduct of the examination under Subsection A above. Any persons so
retained shall be under the direction and control of the commissioner and shall act in a purely advisory
capacity.

D. Expenses. Each registered insurer producing for examination records, books and papers pursuant to
Subsection A above shall be liable for and shall pay the expense of examination in accordance with Section
[insert applicable section].

E. Compelling Production. In the event the insurer fails to comply with an order, the commissioner shall have
the power to examine the affiliates to obtain the information. The commissioner shall also have the power
to issue subpoenas, to administer oaths, and to examine under oath any person for purposes of determining
compliance with this section. Upon the failure or refusal of any person to obey a subpoena, the
commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter
an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the
court order shall be punishable as contempt of court. Every person shall be obliged to attend as a witness at
the place specified in the subpoena, when subpoenaed, anywhere within the state. He or she shall be
entitled to the same fees and mileage, if claimed, as a witness in [insert appropriate statutory reference to
trial-level court in that state], which fees, mileage, and actual expense, if any, necessarily incurred in
securing the attendance of witnesses, and their testimony, shall be itemized and charged against, and be
paid by, the company being examined.

Section 7. Supervisory Colleges

A. Power of Commissioner. With respect to any insurer registered under Section 4, and in accordance with
Subsection C below, the commissioner shall also have the power to participate in a supervisory college for
any domestic insurer that is part of an insurance holding company system with international operations in
order to determine compliance by the insurer with this Chapter. The powers of the commissioner with
respect to supervisory colleges include, but are not limited to, the following:

(1) Initiating the establishment of a supervisory college;

(2) Clarifying the membership and participation of other supervisors in the supervisory college;

(3) Clarifying the functions of the supervisory college and the role of other regulators, including the
establishment of a group-wide supervisor;

(4) Coordinating the ongoing activities of the supervisory college, including planning meetings,
supervisory activities, and processes for information sharing; and

(5) Establishing a crisis management plan.

B. Expenses. Each registered insurer subject to this section shall be liable for and shall pay the reasonable
expenses of the commissioner’s participation in a supervisory college in accordance with Subsection C
below, including reasonable travel expenses. For purposes of this section, a supervisory college may be
convened as either a temporary or permanent forum for communication and cooperation between the
regulators charged with the supervision of the insurer or its affiliates, and the commissioner may establish a
regular assessment to the insurer for the payment of these expenses.

C. Supervisory College. In order to assess the business strategy, financial position, legal and regulatory
position, risk exposure, risk management and governance processes, and as part of the examination of
individual insurers in accordance with Section 6, the commissioner may participate in a supervisory college
with other regulators charged with supervision of the insurer or its affiliates, including other state, federal
and international regulatory agencies. The commissioner may enter into agreements in accordance with
Section 8C providing the basis for cooperation between the commissioner and the other regulatory agencies, and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the commissioner to regulate or supervise the insurer or its affiliates within its jurisdiction.

Section 7.1. Group-wide Supervision of Internationally Active Insurance Groups

A. The commissioner is authorized to act as the group-wide supervisor for any internationally active insurance group in accordance with the provisions of this section. However, the commissioner may otherwise acknowledge another regulatory official as the group-wide supervisor where the internationally active insurance group:

(1) Does not have substantial insurance operations in the United States;

(2) Has substantial insurance operations in the United States, but not in this state; or

(3) Has substantial insurance operations in the United States and this state, but the commissioner has determined pursuant to the factors set forth in Subsections B and F that the other regulatory official is the appropriate group-wide supervisor.

An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the commissioner make a determination or acknowledgment as to a group-wide supervisor pursuant to this section.

B. In cooperation with other state, federal and international regulatory agencies, the commissioner will identify a single group-wide supervisor for an internationally active insurance group. The commissioner may determine that the commissioner is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state. However, the commissioner may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group. The commissioner shall consider the following factors when making a determination or acknowledgment under this subsection:

(1) The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group’s written premiums, assets or liabilities;

(2) The place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group;

(3) The location of the executive offices or largest operational offices of the internationally active insurance group;

(4) Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the commissioner determines to be:

   (a) Substantially similar to the system of regulation provided under the laws of this state, or otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

(5) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

However, a commissioner identified under this section as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. The acknowledgment of the group-wide supervisor shall be made after consideration of the factors listed in Paragraphs (1) through (5) above, and shall be made in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the internationally active insurance group, and in consultation with the internationally active insurance group.
C. Notwithstanding any other provision of law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the commissioner shall acknowledge that regulatory official as the group-wide supervisor. However, in the event of a material change in the internationally active insurance group that results in:

(1) The internationally active insurance group’s insurers domiciled in this state holding the largest share of the group’s premiums, assets or liabilities; or

(2) This state being the place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group, the commissioner shall make a determination or acknowledgment as to the appropriate group-wide supervisor for such an internationally active insurance group pursuant to Subsection B.

D. Pursuant to Section 6, the commissioner is authorized to collect from any insurer registered pursuant to Section 4 all information necessary to determine whether the commissioner may act as the group-wide supervisor of an internationally active insurance group or if the commissioner may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the commissioner, the commissioner shall notify the insurer registered pursuant to Section 4 and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than thirty (30) days to provide the commissioner with additional information pertinent to the pending determination. The commissioner shall publish in the [insert name of state administrative record] and on its Internet website the identity of internationally active insurance groups that the commissioner has determined are subject to group-wide supervision by the commissioner.

E. If the commissioner is the group-wide supervisor for an internationally active insurance group, the commissioner is authorized to engage in any of the following group-wide supervision activities:

(1) Assess the enterprise risks within the internationally active insurance group to ensure that:

   (a) The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management, and

   (b) Reasonable and effective mitigation measures are in place;

(2) Request, from any member of an internationally active insurance group subject to the commissioner’s supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the internationally active insurance group regarding:

   (a) Governance, risk assessment and management,

   (b) Capital adequacy, and

   (c) Material intercompany transactions;

(3) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of such internationally active insurance group that are engaged in the business of insurance;

(4) Communicate with other state, federal and international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the confidentiality provisions of Section 8, through supervisory colleges as set forth in Section 7 or otherwise;
(5) Enter into agreements with or obtain documentation from any insurer registered under Section 4, any member of the internationally active insurance group, and any other state, federal and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the commissioner's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

(6) Other group-wide supervision activities, consistent with the authorities and purposes enumerated above, as considered necessary by the commissioner.

F. If the commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the NAIC is the group-wide supervisor, the commissioner is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that:

(1) The commissioner's cooperation is in compliance with the laws of this state; and

(2) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the commissioner's activities as a group-wide supervisor for other internationally active insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the commissioner is authorized to refuse recognition and cooperation.

G. The commissioner is authorized to enter into agreements with or obtain documentation from any insurer registered under Section 4, any affiliate of the insurer, and other state, federal and international regulatory agencies for members of the internationally active insurance group, that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

H. The commissioner may promulgate regulations necessary for the administration of this section.

I. A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the commissioner's participation in the administration of this section, including the engagement of attorneys, actuaries and any other professionals and all reasonable travel expenses.

Section 8. Confidential Treatment

A. Documents, materials or other information in the possession or control of the Department of Insurance that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to Section 6 and all information reported or provided to the Department of Insurance pursuant to Section 3B(12) and (13), Section 4, Section 5 and Section 7.1 are recognized by this state as being proprietary and to contain trade secrets, and shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner’s official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by the publication thereof, in which event the commissioner may publish all or any part in such manner as may be deemed appropriate.

(1) For purposes of the information reported and provided to the Department of Insurance pursuant to Section 4L(2), the commissioner shall maintain the confidentiality of the group capital calculation and group capital ratio produced within the calculation and any group capital information received from an insurance holding company supervised by the Federal Reserve Board or any U.S. group wide supervisor.

(2) For purposes of the information reported and provided to the [Department of Insurance] pursuant
to Section 4L(3), the commissioner shall maintain the confidentiality of the liquidity stress test results and supporting disclosures and any liquidity stress test information received from an insurance holding company supervised by the Federal Reserve Board and non-U.S. group wide supervisors.

Drafting note: This group capital calculation and group capital ratio includes confidential information and filings received from insurance holding companies supervised by the Federal Reserve Board. Similarly, the liquidity stress test may include confidential information and filings received from insurance holding companies supervised by the Federal Reserve Board. The confidential treatment afforded to group capital calculation filings includes any Federal Reserve Board group capital filings and information.

B. Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner or with whom such documents, materials or other information are shared pursuant to this Act shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to Subsection A.

C. In order to assist in the performance of the commissioner’s duties, the commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection A, including proprietary and trade secret documents and materials with other state, federal and international regulatory agencies, with the NAIC, and with any third-party consultants designated by the commissioner, with state, federal, and international law enforcement authorities, including members of any supervisory college described in Section 7, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information, and has verified in writing the legal authority to maintain confidentiality.

(2) Notwithstanding paragraph (1) above, the commissioner may only share confidential and privileged documents, material, or information reported pursuant to Section 4L(1) with commissioners of states having statutes or regulations substantially similar to Subsection A and who have agreed in writing not to disclose such information.

(3) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade-secret information from the NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(4) Shall enter into written agreements with the NAIC and any third-party consultant designated by the commissioner governing sharing and use of information provided pursuant to this Act consistent with this subsection that shall:

   (a) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant designated by the commissioner pursuant to this Act, including procedures and protocols for sharing by the NAIC with other state, federal or international regulators. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials or other information and has verified in writing the legal authority to maintain such confidentiality;

   (b) Specify that ownership of information shared with the NAIC or a third party consultant pursuant to this Act remains with the commissioner and the NAIC’s or a third-party consultant’s, as designated by the commissioner, use of the information is subject to the direction of the commissioner;

   (c) Excluding documents, material or information reported pursuant to Section 4L(3), prohibit the NAIC or third-party consultant designated by the commissioner from storing the information shared pursuant to this Act in a permanent database after the underlying

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(d) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant designated by the commissioner pursuant to this Act is subject to a request or subpoena to the NAIC or a third-party consultant designated by the commissioner for disclosure or production; and

(e) Require the NAIC or a third-party consultant designated by the commissioner to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant designated by the commissioner may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant designated by the commissioner pursuant to this Act.

(f) For documents, material or information reporting pursuant to Section 4L(3), in the case of an agreement involving a third-party consultant, provide for notification of the identity of the consultant to the applicable insurers.

D. The sharing of information by the commissioner pursuant to this Act shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of this Act.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection C.

F. Documents, materials or other information in the possession or control of the NAIC or a third-party consultant designated by the commissioner pursuant to this Act shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

G. The group capital calculation and resulting group capital ratio required under Section 4L(2) and the liquidity stress test along with its results and supporting disclosures required under Section 4L(3) are regulatory tools for assessing group risks and capital adequacy and group liquidity risks, respectively, and are not intended as a means to rank insurers or insurance holding company systems generally. Therefore, except as otherwise may be required under the provisions of this Act, the making, publishing, disseminating, circulating or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station or any electronic means of communication available to the public, or in any other way as an advertisement, announcement or statement containing a representation or statement with regard to the group capital calculation, group capital ratio, the liquidity stress test results, or supporting disclosures for the liquidity stress test of any insurer or any insurer group, or of any component derived in the calculation by any insurer, broker, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the group capital calculation, resulting group capital ratio, an inappropriate comparison of any amount to an insurer’s or insurance group’s group capital calculation or resulting group capital ratio, liquidity stress test result, supporting disclosures for the liquidity stress test, or an inappropriate comparison of any amount to an insurer’s or insurance group’s liquidity stress test result or supporting disclosures is published in any written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement or the inappropriateness, as the case may be, then the insurer may publish announcements in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

Drafting Note: In Section 8C(4) above, the exclusions in sub-items (ii), (iii) and (vi) are the result of the Liquidity Stress Test primary purpose, which is to be used as a tool for assessing macroprudential risks by the NAIC Financial Stability Task Force assisted by NAIC staff, including trend analysis over time. Provisions against the NAIC owning the information, databasing the results and disclosures, and obtaining written consent from the insurer when a consultant is involved were deemed inappropriate.

Section 9. Rules and Regulations

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The commissioner may, upon notice and opportunity for all interested persons to be heard, issue such rules, regulations and orders as shall be necessary to carry out the provisions of this Act.

Section 10. Injunctions, Prohibitions Against Voting Securities, Sequestration of Voting Securities

A. Injunctions. Whenever it appears to the commissioner that any insurer or any director, officer, employee or agent thereof has committed or is about to commit a violation of this Act or of any rule, regulation or order issued by the commissioner hereunder, the commissioner may apply to the [insert title] Court for the county in which the principal officer of the insurer is located or if the insurer has no office in this state then to the [insert title] Court for [insert county] County for an order enjoining the insurer or director, officer, employee or agent thereof from violating or continuing to violate this Act or any rule, regulation or order, and for such other equitable relief as the nature of the case and the interest of the insurer’s policyholders, creditors and shareholders or the public may require.

B. Voting of Securities; When Prohibited. No security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in contravention of the provisions of this Act or of any rule, regulation or order issued by the commissioner hereunder may be voted at any shareholder’s meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding; but no action taken at any such meeting shall be invalidated by the voting of the securities, unless the action would materially affect control of the insurer or unless the courts of this state have so ordered. If an insurer or the commissioner has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the provisions of this Act or of any rule, regulation or order issued by the commissioner hereunder; the insurer or the commissioner may apply to the [insert title] Court for the county in which the insurer has its principle place of business to enjoin any offer, request, invitation, agreement or acquisition made in contravention of Section 3 or any rule, regulation or order issued by the commissioner thereunder to enjoin the voting of any security so acquired, to void any vote of the security already cast at any meeting of shareholders and for such other equitable relief as the nature of the case and the interest of the insurer’s policyholders, creditor and shareholders or the public may require.

C. Sequestration of Voting Securities. In any case where a person has acquired or is proposing to acquire any voting securities in violation of this Act or any rule, regulation or order issued by the commissioner hereunder, the [insert title] Court for [insert county] County or the [insert title] Court for the county in which the insurer has its principal place of business may, on such notice as the court deems appropriate, upon the application of the insurer or the commissioner, seize or sequester any voting securities of the insurer owned directly or indirectly by the person, and issue such order as may be appropriate to effectuate the provisions of this Act.

Notwithstanding any other provisions of law, for the purposes of this Act the situs of the ownership of the securities of domestic insurers shall be deemed to be in this state.

Section 11. Sanctions

A. Any insurer failing, without just cause, to file any registration statement as required in this Act shall be required, after notice and hearing, to pay a penalty of $[insert amount] for each day’s delay, to be recovered by the commissioner of Insurance and the penalty so recovered shall be paid into the General Revenue Fund of this state. The maximum penalty under this section is $[insert amount]. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

B. Every director or officer of an insurance holding company system who knowingly violates, participates in, or assents to, or who knowingly shall permit any of the officers or agents of the insurer to engage in transactions or make investments which have not been properly reported or submitted pursuant to Section 4A, 5A(2), or 5B, or which violate this Act, shall pay, in their individual capacity, a civil forfeiture of not more than $[insert amount] per violation, after notice and hearing before the commissioner. In determining the amount of the civil forfeiture, the commissioner shall take into account the appropriateness of the forfeiture with respect to the gravity of the violation, the history of previous violations, and such other
matters as justice may require.

C. Whenever it appears to the commissioner that any insurer subject to this Act or any director, officer, employee or agent thereof has engaged in any transaction or entered into a contract which is subject to Section 5 of this Act and which would not have been approved had the approval been requested, the commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing the commissioner may also order the insurer to void any contracts and restore the status quo if the action is in the best interest of the policyholders, creditors or the public.

D. Whenever it appears to the commissioner that any insurer subject to this Act or any director, officer, employee or agent thereof has engaged in any transaction or entered into a contract or agreement which is subject to Section 5 of this Act and which have not been properly reported or submitted pursuant to Section 4A, 5A(2), or 5B, or which violate Section 5(A) of this Act, the commissioner has the power to order the insurer to require the affiliated person(s) to the transaction to obtain and maintain a bond for the protection of the insurer for the duration of the contract or agreement, as required by the commissioner at any time. The bond amount should be no less than the amount specified by the commissioner.

Drafting Note: The intent of the bond is to ensure the affiliated services provided under the contract are fulfilled, which may be referred to as a "performance bond".

E. Whenever it appears to the commissioner that any insurer or any director, officer, employee or agent thereof has committed a willful violation of this Act, the commissioner may cause criminal proceedings to be instituted by the [insert title] Court for the county in which the principal office of the insurer is located or if the insurer has no office in this state, then by the [insert county] Court for [insert title] County against the insurer or the responsible director, officer, employee or agent thereof. Any insurer which willfully violates this Act may be fined not more than $[insert amount]. Any individual who willfully violates this Act may be fined in his or her individual capacity not more than $[insert amount] or be imprisoned for not more than one to three (3) years or both.

F. Any officer, director or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made any false statements or false reports or false filings with the intent to deceive the commissioner in the performance of his or her duties under this Act, upon conviction shall be imprisoned for not more than [insert amount] years or fined $[insert amount] or both. Any fines imposed shall be paid by the officer, director or employee in his or her individual capacity.

G. Whenever it appears to the commissioner that any person has committed a violation of Section 3 of this Act and which prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with [insert appropriate statutory reference related to orders of supervision].

Section 12. Receivership

Whenever it appears to the commissioner that any person has committed a violation of this Act which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders or the public, then the commissioner may proceed as provided in Section [insert applicable section] of this Chapter to take possessions of the property of the domestic insurer and to conduct its business.

Section 13. Recovery

A. If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer, (i) from any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions (other than distributions of shares of the same class of stock) paid by the insurer on its capital stock, or (ii) any payment in the form of a bonus, termination settlement or extraordinary lump sum salary adjustment made by the insurer or its subsidiary to a director, officer or employee, where the distribution or payment pursuant to (i) or (ii) is made at any time during the one year preceding the petition for liquidation, conservation or rehabilitation, as the case may be, subject to the limitations of Subsections B, C, and D of
this section.

B. No distribution shall be recoverable if the parent or affiliate shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

C. Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time the distributions were paid shall be liable up to the amount of distributions or payments under Subsection A which the person received. Any person who otherwise controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions that would have been received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

D. The maximum amount recoverable under this section shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

E. To the extent that any person liable under Subsection C of this section is insolvent or otherwise fails to pay claims due from it, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the parent corporation or holding company or person who otherwise controlled it.

Section 14. Revocation, Suspension, or Nonrenewal of Insurer’s License

Whenever it appears to the commissioner that any person has committed a violation of this Act which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the commissioner may, after giving notice and an opportunity to be heard, suspend, revoke or refuse to renew the insurer’s license or authority to do business in this state for such period as the commissioner finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law.

Section 15. Judicial Review, Mandamus

A. Any person aggrieved by any act, determination, rule, regulation or order or any other action of the commissioner pursuant to this Act may appeal to the [insert title] Court for [insert county] County. The court shall conduct its review without a jury and by trial de novo, except that if all parties, including the commissioner, so stipulate, the review shall be confined to the record. Portions of the record may be introduced by stipulation into evidence in a trial de novo as to those parties so stipulating.

B. The filing of an appeal pursuant to this section shall stay the application of any rule, regulation, order or other action of the commissioner to the appealing party unless the court, after giving the party notice and an opportunity to be heard, determines that a stay would be detrimental to the interest of policyholders, shareholders, creditors or the public.

C. Any person aggrieved by any failure of the commissioner to act or make a determination required by this Act may petition the [insert title] Court for [insert county] County for a writ in the nature of a mandamus or a peremptory mandamus directing the commissioner to act or make a determination.

Section 16. Conflict with Other Laws

All laws and parts of laws of this state inconsistent with this Act are hereby superseded with respect to matters covered by this Act.

Section 17. Separability of Provisions

If any provision of this Act or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provisions or application, and for this purpose the provisions of this Act are separable.
Section 18. Effective Date

This Act shall take effect thirty (30) days from its passage.
Alternative Section 1. Findings

A. It is hereby found and declared that it may not be inconsistent with the public interest and the interest of policyholders and shareholders to permit insurers to:

(1) Engage in activities which would enable them to make better use of management skills and facilities;

(2) Diversify into new lines of business through acquisition or organization of subsidiaries;

(3) Have free access to capital markets which could provide funds for insurers to use in diversification programs;

(4) Implement sound tax planning conclusions; and

(5) Serve the changing needs of the public and adapt to changing conditions of the social, economic and political environment, so that insurers are able to compete effectively and to meet the growing public demand for institutions capable of providing a comprehensive range of financial services.

B. It is further found and declared that the public interest and the interests of policyholders and shareholders are or may be adversely affected when:

(1) Control of an insurer is sought by persons who would utilize such control adversely to the interests of policyholders or shareholders;

(2) Acquisition of control of an insurer would substantially lessen competition or create a monopoly in the insurance business in this state;

(3) An insurer which is part of an insurance holding company system is caused to enter into transactions or relationships with affiliated companies on terms which are not fair and reasonable; or

(4) An insurer pays dividends to shareholders which jeopardize the financial condition of such insurers.

C. It is hereby declared that the policies and purposes of this Act are to promote the public interest by:

(1) Facilitating the achievement of the objectives enumerated in Subsection A;

(2) Requiring disclosure of pertinent information relating to changes in control of an insurer;

(3) Requiring disclosure by an insurer of material transactions and relationships between the insurer and its affiliates, including certain dividends to shareholders paid by the insurer; and

(4) Providing standards governing material transactions between the insurer and its affiliates.

D. It is further declared that it is desirable to prevent unnecessary multiple and conflicting regulation of insurers. Therefore, this state shall exercise regulatory authority over domestic insurers and unless otherwise provided in this Act, not over nondomestic insurers, with respect to the matters contained herein.
Alternative Section 2. Subsidiaries of Insurers

A. Authorization. Any domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries engaged in the following kinds of business:

1. Any kind of insurance business authorized by the jurisdiction in which it is incorporated;

2. Acting as an insurance broker or as an insurance agent for its parent or for any of its parent’s insurer subsidiaries;

3. Investing, reinvesting or trading in securities for its own account, that of its parent, a subsidiary of its parent, or an affiliate or subsidiary;

4. Management of an investment company subject to or registered pursuant to the Investment Company Act of 1940, as amended, including related sales and services;

5. Acting as a broker-dealer subject to or registered pursuant to the Securities Exchange Act of 1934, as amended;

6. Rendering investment advice to governments, government agencies, corporations or other organizations or groups;

7. Rendering other services related to the operations of an insurance business, such as actuarial, loss prevention, safety engineering, data processing, accounting, claims, appraisal and collection services;

8. Ownership and management of assets which the parent corporation could itself own or manage;

Drafting Note: The aggregate investment by the insurer and its subsidiaries acquired or organized pursuant to this paragraph should not exceed the limitations applicable to such investments by the insurer.

9. Acting as administrative agent for a governmental instrumentality that is performing an insurance function;

10. Financing of insurance premiums, agents and other forms of consumer financing;

11. Any other business activity determined by the commissioner to be reasonably ancillary to an insurance business; and

12. Owning a corporation or corporations engaged or organized to engage exclusively in one or more of the businesses specified in this section.

Chronological Summary of Action (all references are to the Proceedings of the NAIC):

1993 Proc. 4th Quarter 11, 33, 307, 310, 312-328 (amended and reprinted).
1997 Proc. 4th Quarter 11 (amendments adopted).
2011 Proc. 1st Quarter 1 1-11 (amended).
Fall 2020 (amended).
INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION
WITH REPORTING FORMS AND INSTRUCTIONS

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Section 1. Authority

These regulations are promulgated pursuant to the authority granted by Sections [insert applicable sections] and [insert applicable section] of the Insurance Law.

Note: Optional for those states in which similar provisions are normally used.

Section 2. Purpose

The purpose of these regulations is to set forth rules and procedural requirements which the Commissioner deems necessary to carry out the provisions of the NAIC Insurance Holding Company System Regulatory Act [insert applicable sections] of the Insurance Code hereinafter referred to as “the Act.” The information called for by these regulations is hereby declared to be necessary and appropriate in the public interest and for the protection of the policyholders in this State.

Editor’s Note: Insert the title of the chief insurance regulatory official wherever the term “commissioner” appears.

Drafting Note: Optional for those states in which similar provisions are normally used.
Section 3. Severability Clause

If any provision of these regulations, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect other provisions or applications of these regulations which can be given effect without the invalid provision or application, and to that end the provisions of these regulations are severable.

Drafting Note: Optional for those states in which similar provisions are normally used.

Section 4. Forms - General Requirements

A. Forms A, B, C, D, E and F are intended to be guides in the preparation of the statements required by Sections 3, 3.1, 4, and 5 of the Act. They are not intended to be blank forms which are to be filled in. The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

B. [Insert number] complete copies of each statement including exhibits and all other papers and documents filed as a part thereof, shall be filed with the Commissioner by personal delivery or mail addressed to: Insurance Commissioner of the State of [insert state and address], Attention: [insert name - title]. At least one of the copies shall be signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of the power of attorney or other authority shall also be filed with the statement.

C. If an applicant requests a hearing on a consolidated basis under Section 3D(3) of the Act, in addition to filing the Form A with the commissioner, the applicant shall file a copy of Form A with the National Association of Insurance Commissioners (NAIC) in electronic form.

D. Statements should be prepared electronically. Statements shall be easily readable and suitable for review and reproduction. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency normally shall be converted into United States currency.

Drafting Note: Section 4 may be omitted if it is included as instructions on Forms A, B, C, D, E and F.

Section 5. Forms - Incorporation by Reference, Summaries and Omissions

A. Information required by any item of Form A, Form B, Form D, Form E or Form F may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in answer or partial answer to any item of Form A, Form B, Form D, Form E or Form F provided the document is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits if the documents are extensive. Documents currently on file with the Commissioner which were filed within three (3) years need not be attached as exhibits. References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item. Matter shall not be incorporated by reference in any case where the incorporation would render the statement incomplete, unclear or confusing.
B. Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to the statement, the summary or outline may incorporate by reference particular parts of any exhibit or document currently on file with the Commissioner which was filed within three (3) years and may be qualified in its entirety by such reference. In any case where two (2) or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties thereto, the dates of execution, or other details, a copy of only one of the documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which the documents differ from the documents, a copy of which is filed.

Drafting Note: Section 5 may be omitted if it is included as instructions on Forms A, B, D, E and F.

Section 6. Forms-Information Unknown or Unavailable and Extension of Time to Furnish

If it is impractical to furnish any required information, document or report at the time it is required to be filed, there shall be filed with the Commissioner a separate document:

A. Identifying the information, document or report in question;
B. Stating why the filing thereof at the time required is impractical; and
C. Requesting an extension of time for filing the information, document or report to a specified date. The request for extension shall be deemed granted unless the Commissioner within [XX] days after receipt thereof enters an order denying the request.

Drafting Note: Section 6 may be omitted if it is included as instruction on Forms A, B, C, D, E and F.

Section 7. Forms - Additional Information and Exhibits

In addition to the information expressly required to be included in Form A, Form B, Form C, Form D, Form E and Form F, the Commissioner may request such further material information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as it may desire in addition to those expressly required by the statement. The exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Changes to Forms A, B, C, D, E or F shall include on the top of the cover page the phrase: “Change No. [insert number] to” and shall indicate the date of the change and not the date of the original filing.

Drafting Note: Section 7 may be omitted if it included as instructions on Forms A, B, C, D, E and F.

Section 8. Definitions

A. “Executive officer” means chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.
B. “Ultimate controlling person” means that person which is not controlled by any other person.
C. Unless the context otherwise requires, other terms found in these regulations and in Section 1 of the Act are used as defined in the Act. Other nomenclature or terminology is according to the Insurance Code, or industry usage if not defined by the Code.

Drafting Note: If regulation Section 2 is not adopted by the state, the following definition should be added to this section:
““The Act” means the Insurance Holding Company System Regulatory Act [insert applicable sections of the Insurance Code].
Section 9. Subsidiaries of Domestic Insurers

The authority to invest in subsidiaries under Section 2B of the Act is in addition to any authority to invest in subsidiaries which may be contained in any other provision of the Insurance Code.

Section 10. Acquisition of Control - Statement Filing

A person required to file a statement pursuant to Section 3 of the Act shall furnish the required information on Form A, hereby made a part of this regulation. Such person shall also furnish the required information on Form E, hereby made a part of this regulation and described in Section 13 of this regulation.

Section 11. Amendments to Form A

The applicant shall promptly advise the Commissioner of any changes in the information furnished on Form A arising subsequent to the date upon which the information was furnished but prior to the Commissioner’s disposition of the application.

Section 12. Acquisition of Section 3A(4) Insurers

A. If the person being acquired is deemed to be a “domestic insurer” solely because of the provisions of Section 3A(4) of the Act, the name of the domestic insurer on the cover page should be indicated as follows:

“ABC Insurance Company, a subsidiary of XYZ Holding Company.”

B. Where a Section 3A(4) insurer is being acquired, references to “the insurer” contained in Form A shall refer to both the domestic subsidiary insurer and the person being acquired.

Section 13. Pre-Acquisition Notification

If a domestic insurer, including any person controlling a domestic insurer, is proposing a merger or acquisition pursuant to Section 3A(1) of the Act, that person shall file a pre-acquisition notification form, Form E, which was developed pursuant to Section 3.1C(1) of the Act.

Additionally, if a non-domiciliary insurer licensed to do business in this state is proposing a merger or acquisition pursuant to Section 3.1 of the Act, that person shall file a pre-acquisition notification form, Form E. No pre-acquisition notification form need be filed if the acquisition is beyond the scope of Section 3.1 as set forth in Section 3.1B(2).

In addition to the information required by Form E, the Commissioner may wish to require an expert opinion as to the competitive impact of the proposed acquisition.

Section 14. Annual Registration of Insurers - Statement Filing

An insurer required to file an annual registration statement pursuant to Section 4 of the Act shall furnish the required information on Form B, hereby made a part of these regulations.

Section 15. Summary of Registration - Statement Filing

An insurer required to file an annual registration statement pursuant to Section 4 of the Act is also required to furnish information required on Form C, hereby made a part of these regulations.
Section 16. Amendments to Form B

A. An amendment to Form B shall be filed within fifteen (15) days after the end of any month in which there is a material change to the information provided in the annual registration statement.

B. Amendments shall be filed in the Form B format with only those items which are being amended reported. Each amendment shall include at the top of the cover page “Amendment No. [insert number] to Form B for [insert year]” and shall indicate the date of the change and not the date of the original filings.

Drafting Note: Section 16 may be omitted if Section 5A(2) of the Model Act has been adopted and amendments to the registration statement are therefore not required by the Act.

Section 17. Alternative and Consolidated Registrations

A. Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register under Section 4 of the Act. A registration statement may include information not required by the Act regarding any insurer in the insurance holding company system even if the insurer is not authorized to do business in this State. In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report which it is required to file in its State of domicile, provided:

1. The statement or report contains substantially similar information required to be furnished on Form B; and

2. The filing insurer is the principal insurance company in the insurance holding company system.

B. The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer, shall set forth a brief statement of facts which will substantiate the filing insurer’s claim that it, in fact, is the principal insurer in the insurance holding company system.

C. With the prior approval of the Commissioner, an unauthorized insurer may follow any of the procedures which could be done by an authorized insurer under Subsection A above.

D. Any insurer may take advantage of the provisions of Section 4H or 4I of the Act without obtaining the prior approval of the Commissioner. The Commissioner, however, reserves the right to require individual filings if he or she deems such filings necessary in the interest of clarity, ease of administration or the public good.

Section 18. Disclaimers and Termination of Registration

A. A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person (hereinafter referred to as the “subject”) shall contain the following information:

1. The number of authorized, issued and outstanding voting securities of the subject;

2. With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject’s voting securities which are held of record or known to be beneficially owned, and the number of shares concerning which there is a right to acquire, directly or indirectly;

3. All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person;

4. A statement explaining why the person should not be considered to control the subject.
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B. A request for termination of registration shall be deemed to have been granted unless the Commissioner, within thirty (30) days after receipt of the request, notifies the registrant otherwise.

Section 19. Transactions Subject to Prior Notice - Notice Filing

A. An insurer required to give notice of a proposed transaction pursuant to Section 5 of the Act shall furnish the required information on Form D, hereby made a part of these regulations.

B. Agreements for cost sharing services and management services shall at a minimum and as applicable:

1. Identify the person providing services and the nature of such services;
2. Set forth the methods to allocate costs;
3. Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual;
4. Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;
5. State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;
6. Define books and records and data of the insurer to include all books and records and data developed or maintained under or related to the agreement, that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate;
7. Specify that all books and records and data of the insurer are and remain the property of the insurer, and are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation from all other persons records and data;
8. State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer;
9. Include standards for termination of the agreement with and without cause;
10. Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services, and for any actions by the affiliate which violate provisions of the agreement required in Subsections 19B(11), 19B(12), 19B(13), 19B(14) and 19B(15) of this regulation;
11. Specify that, if the insurer is placed in supervision, seizure, conservatorship, or receivership pursuant to [supervision and receivership acts], a receivership or seized by the commissioner under the State Receivership Act:
   (a) all of the rights of the insurer under the agreement extend to the receiver or commissioner to the extent permitted by [law of the state];
   (b) all books and records and data of the insurer will immediately be made available to the receiver or the commissioner, shall be made available in a usable format, and shall be turned over to the receiver or commissioner immediately upon the receiver or the commissioner’s request, at no cost to the receiver or the commissioner; and,
   (c) The affiliated person(s) will make available all employees essential to the operations of the insurer and the services associated therewith for the immediate continued
Section 20. Enterprise Risk Report

The ultimate controlling person of an insurer required to file an enterprise risk report pursuant to Section 4L(1) of the Act shall furnish the required information on Form F, hereby made a part of these regulations.

Section 21. Group Capital Calculation

A. Where an insurance holding company system has previously filed the annual group capital calculation at least once, the lead state commissioner has the discretion to exempt the ultimate controlling person from filing the annual group capital calculation if the lead state commissioner makes a determination based upon that filing that the insurance holding company system meets all of the following criteria:

1. Has annual direct written and unaffiliated assumed premium (including international direct and assumed premium), but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than $1,000,000,000;

2. Has no insurers within its holding company structure that are domiciled outside of the United States or one of its territories;

3. Has no banking, depository or other financial entity that is subject to an identified regulatory capital framework within its holding company structure;

4. The holding company system attests that there are no material changes in the transactions between insurers and non-insurers in the group that have occurred since the last filing of the annual group capital; and

5. The non-insurers within the holding company system do not pose a material financial risk to the insurer’s ability to honor policyholder obligations.

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performance of the essential services ordered or directed by the receiver or commissioner.

(12) Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed into supervision, seizure, conservatorship, or receivership pursuant to supervision and receivership acts; the State Receivership Act; and

(13) Specify that the affiliate will provide the essential services for a minimum period of time after termination of the agreement, if the insurer is placed into supervision, seizure, conservatorship, or receivership pursuant to supervision and receivership acts, as ordered or directed by the receiver or commissioner. Performance of the essential services will continue to be provided without regard to pre-receivership unpaid fees, so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court.

(14) Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding supervision, seizure, conservatorship, or receivership pursuant to supervision and receivership acts; a seizure by the commissioner under the State Receivership Act, and will make them available to the receiver or commissioner as ordered or directed by the receiver or commissioner, for so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court.

(15) Specify that, in furtherance of the cooperation between the receiver and the affected guaranty association(s) and subject to the receiver's authority over the insurer, if the insurer is placed into supervision, seizure, conservatorship, or receivership pursuant to supervision and receivership acts, and portions of the insurer's policies or contracts are covered by one or more guaranty associations, the affiliate's commitments under Subsections 19B(11), 19B(12), 19B(13) and 19B(14) of this regulation will extend to the guaranty association(s) providing such coverage.
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B. Where an insurance holding company system has previously filed the annual group capital calculation at least once, the lead state commissioner has the discretion to accept in lieu of the group capital calculation a limited group capital filing if:

(1) The insurance holding company system has annual direct written and unaffiliated assumed premium (including international direct and assumed premium), but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than $1,000,000,000; and all of the following additional criteria are met:

(a) Has no insurers within its holding company structure that are domiciled outside of the United States or one of its territories;

(b) Does not include a banking, depository or other financial entity that is subject to an identified regulatory capital framework; and

(c) The holding company system attests that there are no material changes in transactions between insurers and non-insurers in the group that have occurred since the last filing of the report to the lead state commissioner and the non-insurers within the holding company system do not pose a material financial risk to the insurers ability to honor policyholder obligations.

C. For an insurance holding company that has previously met an exemption with respect to the group capital calculation pursuant Section 21A or 21B of this regulation, the lead state commissioner may require at any time the ultimate controlling person to file an annual group capital calculation, completed in accordance with the NAIC Group Capital Calculation Instructions, if any of the following criteria are met:

(1) Any insurer within the insurance holding company system is in a Risk-Based Capital action level event as set forth in [insert cross-reference to appropriate section of Risk-Based Capital (RBC) Model Act] or a similar standard for a non-U.S. insurer; or

(2) Any insurer within the insurance holding company system meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in [insert cross-reference to appropriate section of Model Regulation to Define Standards and Commissioner’s Authority for Companies Deemed to be in Hazardous Financial Condition]; or

(3) Any insurer within the insurance holding company system otherwise exhibits qualities of a troubled insurer as determined by the lead state commissioner based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests.

D. A non-U.S. jurisdiction is considered to “recognize and accept” the group capital calculation if it satisfies the following criteria:

(1) With respect to the [insert cross-reference to Section 4L(2)(d) of the Model Act]

(a) The non-U.S. jurisdiction recognizes the U.S. state regulatory approach to group supervision and group capital, by providing confirmation by a competent regulatory authority, in such jurisdiction, that insurers and insurance groups whose lead state is accredited under the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction; or

(b) Where no U.S. insurance groups operate in the non-U.S. jurisdiction, that non-U.S. jurisdiction indicates formally in writing to the lead state with a copy to the International Association of Insurance Supervisors that the group capital calculation is an acceptable
international capital standard. This will serve as the documentation otherwise required in Section 21D(1)(a).

(2) The non-U.S. jurisdiction provides confirmation by a competent regulatory authority in such jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and such jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC. The commissioner shall determine, in consultation with the NAIC Committee Process, if the requirements of the information sharing agreements are in force.

E. A list of non-U.S. jurisdictions that “recognize and accept” the group capital calculation will be published through the NAIC Committee Process:

(1) A list of jurisdictions that “recognize and accept” the group capital calculation pursuant to [insert cross-reference to Sections 4L(2)(d)], is published through the NAIC Committee Process to assist the lead state commissioner in determining which insurers shall file an annual group capital calculation. The list will clarify those situations in which a jurisdiction is exempted from filing under [insert cross-reference to Sections 4L(2)(d)]. To assist with a determination under 4L(2)(e), the list will also identify whether a jurisdiction that is exempted under either [insert cross-reference to Sections 4L(2)(c) and 4L(2)(d)] requires a group capital filing for any U.S. based insurance group’s operations in that non-U.S. jurisdiction.

(2) For a non-U.S. jurisdiction where no U.S. insurance groups operate, the confirmation provided to meet the requirement of Section 21D(1)(b) will serve as support for recommendation to be published as a jurisdiction that “recognizes and accepts” the group capital calculation through the NAIC Committee Process.

(3) If the lead state commissioner makes a determination pursuant to Section 4L(2)(d) that differs from the NAIC List, the lead state commissioner shall provide thoroughly documented justification to the NAIC and other states.

(4) Upon determination by the lead state commissioner that a non-U.S. jurisdiction no longer meets one or more of the requirements to “recognize and accept” the group capital calculation, the lead state commissioner may provide a recommendation to the NAIC that the non-U.S. jurisdiction be removed from the list of jurisdictions that “recognize and accepts” the group capital calculation.

Section 22. Extraordinary Dividends and Other Distributions

A. Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:

(1) The amount of the proposed dividend;

(2) The date established for payment of the dividend;

(3) A statement as to whether the dividend is to be in cash or other property and, if in property, a description thereof, its cost, and its fair market value together with an explanation of the basis for valuation;

(4) A copy of the calculations determining that the proposed dividend is extraordinary. The work paper shall include the following information:

(a) The amounts, dates and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurer’s own securities) paid within the period of twelve (12) consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;
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(b) Surplus as regards policyholders (total capital and surplus) as of the 31st day of December next preceding;

(c) If the insurer is a life insurer, the net gain from operations for the 12-month period ending the 31st day of December next preceding;

(d) If the insurer is not a life insurer, the net income less realized capital gains for the 12-month period ending the 31st day of December next preceding and the two preceding 12-month periods; and

(e) If the insurer is not a life insurer, the dividends paid to stockholders excluding distributions of the insurer's own securities in the preceding two (2) calendar years;

(5) A balance sheet and statement of income for the period intervening from the last annual statement filed with the Commissioner and the end of the month preceding the month in which the request for dividend approval is submitted; and

(6) A brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs.

B. Subject to Section 5B of the Act, each registered insurer shall report to the Commissioner all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof, including the same information required by Subsection A(4).

Section 23. Adequacy of Surplus

The factors set forth in Section 5D of the Act are not intended to be an exhaustive list. In determining the adequacy and reasonableness of an insurer's surplus no single factor is necessarily controlling. The Commissioner instead will consider the net effect of all of these factors plus other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the Commissioner will consider the extent to which each of these factors varies from company to company and in determining the quality and liquidity of investments in subsidiaries, the Commissioner will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.
FORM A

STATEMENT REGARDING THE
ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER

Name of Domestic Insurer

BY

Name of Acquiring Person (Applicant)

Filed with the Insurance Department of

(State of domicile of insurer being acquired)

Dated: ______________________ , 20____

Name, Title, address and telephone number of Individual to Whom Notices and Correspondence Concerning this Statement Should be Addressed:

ITEM 1. METHOD OF ACQUISITION

State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired.

ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT

(a) State the name and address of the applicant seeking to acquire control over the insurer.

(b) If the applicant is not an individual, state the nature of its business operations for the past 5 years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant’s subsidiaries.

(c) Furnish a chart or listing clearly presenting the identities of the interrelationships among the applicant and all affiliates of the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g. corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.

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ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH THE APPLICANT

On the biographical affidavit, include a third party background check, and state the following with respect to (1) the applicant if (s)he is an individual or (2) all persons who are directors, executive officers or owners of 10% or more of the voting securities of the applicant if the applicant is not an individual.

(a) Name and business address.

(b) Present principal business activity, occupation or employment including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on.

(c) Material occupations, positions, offices or employment during the last 5 years, giving the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which each such occupation, position, office or employment was carried on; if any such occupation, position, office or employment required licensing by or registration with any federal, state or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith.

(d) Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last 10 years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.

ITEM 4. NATURE, SOURCE AND AMOUNT OF CONSIDERATION

(a) Describe the nature, source and amount of funds or other considerations used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes and security arrangements relating thereto.

(b) Explain the criteria used in determining the nature and amount of such consideration.

(c) If the source of the consideration is a loan made in the lender’s ordinary course of business and if the applicant wishes the identity of the lender to remain confidential, he must specifically request that the identity be kept confidential.

ITEM 5. FUTURE PLANS OF INSURER

Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate the insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.

ITEM 6. VOTING SECURITIES TO BE ACQUIRED

State the number of shares of the insurer’s voting securities which the applicant, its affiliates and any person listed in Item 3 plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was arrived at.

ITEM 7. OWNERSHIP OF VOTING SECURITIES

State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates or any person listed in Item 3.
ITEM 8. CONTRACTS, ARRANGEMENTS, OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER

Give a full description of any contracts, arrangements or understandings with respect to any voting security of the insurer in which the applicant, its affiliates or any person listed in Item 3 is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom the contracts, arrangements or understandings have been entered into.

ITEM 9. RECENT PURCHASES OF VOTING SECURITIES

Describe any purchases of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement. Include in the description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. State whether any shares so purchased are hypothecated.

ITEM 10. RECENT RECOMMENDATIONS TO PURCHASE

Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement.

ITEM 11. AGREEMENTS WITH BROKER-DEALERS

Describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

ITEM 12. FINANCIAL STATEMENTS AND EXHIBITS

(a) Financial statements, exhibits, and three-year financial projections of the insurer(s) shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the persons identified in Item 2(c) for the preceding 5 fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person’s last fiscal year, if the information is available. The statements may be prepared on either an individual basis, or, unless the Commissioner otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of the person filed with the insurance department of the person’s domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of the state.

(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto, any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by Form A or regulation Sections 4 and 6.
ITEM 13. AGREEMENT REQUIREMENTS FOR ENTERPRISE RISK MANAGEMENT

Applicant agrees to provide, to the best of its knowledge and belief, the information required by Form F within fifteen (15) days after the end of the month in which the acquisition of control occurs.

ITEM 14. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 3 of the Act ________________ has caused this application to be duly signed on its behalf in the City of ________________ and State of on the __________ day of __________, 20_____.

(SEAL) ________________
Name of Applicant

BY ________________
(Name) (Title)

Attest:

___________________________
(Signature of Officer)

___________________________
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated __________, 20_____, for and on behalf of ________________ (Name of Applicant); that (s)he is the ________________ (Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with the instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) __________________________

(Type or print name beneath) __________________________
FORM B

INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of____________________

By

__________________________
Name of Registrant

On Behalf of Following Insurance Companies

Name  Address

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

Date:____________________, 20____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

ITEM 1.  IDENTITY AND CONTROL OF REGISTRANT

Furnish the exact name of each insurer registering or being registered (hereinafter called “the Registrant”), the home office address and principal executive offices of each; the date on which each registrant became part of the insurance holding company system; and the method(s) by which control of each registrant was acquired and is maintained.

ITEM 2.  ORGANIZATIONAL CHART

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of control. As to each person specified in the chart or listing indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile.
ITEM 3. THE ULTIMATE CONTROLLING PERSON

As to the ultimate controlling person in the insurance holding company system furnish the following information:

(a) Name;

(b) Home office address;

(c) Principal executive office address;

(d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.;

(e) The principal business of the person;

(f) The name and address of any person who holds or owns 10% or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned; and

(g) If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.

ITEM 4. BIOGRAPHICAL INFORMATION

If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, furnish the following information for the directors and executive officers of the ultimate controlling person: the individual’s name and address, his or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations. If the ultimate controlling person is an individual, furnish the individual’s name and address, his or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations.

ITEM 5. TRANSACTIONS AND AGREEMENTS

Briefly describe the following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the registrant and its affiliates:

(a) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;

(b) Purchases, sales or exchanges of assets;

(c) Transactions not in the ordinary course of business;

(d) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant’s assets to liability, other than insurance contracts entered into in the ordinary course of the registrant’s business;

(e) All management agreements, service contracts and all cost-sharing arrangements;

(f) Reinsurance agreements;

(g) Dividends and other distributions to shareholders;

(h) Consolidated tax allocation agreements; and
(i) Any pledge of the registrant’s stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

No information need be disclosed if such information is not material for purposes of Section 4 of the Act.

Sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of 1% or less of the registrant’s admitted assets as of the 31st day of December next preceding shall not be deemed material.

Drafting Note: Commissioner may by rule, regulation or order provide otherwise.

The description shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include at least the following: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to the transaction, and relationship of the affiliated parties to the registrant.

ITEM 6. LITIGATION OR ADMINISTRATIVE PROCEEDINGS

A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which the litigation or proceeding is or was pending:

(a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and

(b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.

ITEM 7. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS

The insurer shall furnish a statement that transactions entered into since the filing of the prior year’s annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

ITEM 8. FINANCIAL STATEMENTS AND EXHIBITS

(a) Financial statements and exhibits should be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, the financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person’s latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis; or, unless the Commissioner otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

Other than with respect to the foregoing, such financial statement shall be filed in a standard form and format adopted by the National Association of Insurance Commissioners, unless an alternative form is accepted by the Commissioner. Documentation and financial statements filed with the Securities and Exchange Commission or audited GAAP financial statements shall be deemed to be an appropriate form and format.
Unless the Commissioner otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that the statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of the insurer’s domiciliary state and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of that state.

Any ultimate controlling person who is an individual may file personal financial statements that are reviewed rather than audited by an independent public accountant. The review shall be conducted in accordance with standards for review of personal financial statements published in the Personal Financial Statements Guide by the American Institute of Certified Public Accountants. Personal financial statements shall be accompanied by the independent public accountant's Standard Review Report stating that the accountant is not aware of any material modifications that should be made to the financial statements in order for the statements to be in conformity with generally accepted accounting principles.

(c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Form B or regulation Sections 4 and 6.

ITEM 9. FORM C REQUIRED

A Form C, Summary of Changes to Registration Statement, must be prepared and filed with this Form B.

ITEM 10. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 4 of the Act, Registrant has caused this annual registration statement to be duly signed on its behalf of the City of _____________ and State of _____________ on the _____________ day of _____________, 20 ___.

(SEAL) ____________________________
Name of Applicant

BY ____________________________
(Name) (Title)

Attest:

______________________________
(Signature of Officer)

______________________________
(Title)
CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached annual registration statement dated ______________, 20____, for and on behalf of ___________________(Name of Applicant); that (s)he is the _____________________(Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)________________________________________

(Type or print name beneath)_____________________________
FORM C

SUMMARY OF CHANGES TO REGISTRATION STATEMENT

Filed with the Insurance Department of the State of ________________

By

____________________________________

Name of Registrant

On Behalf of Following Insurance Companies

Name  Address

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

Date: ___________________________, 20____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

____________________________________________________________________________________________

____________________________________________________________________________________________

Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year’s annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include specific references to Item numbers in the annual registration statement and to the terms contained therein.

Changes occurring under Item 2 of Form B insofar as changes in the percentage of each class of voting securities held by each affiliate is concerned, need only be included where such changes are ones which result in ownership or holdings of 10% or more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

Changes occurring under Item 4 of Form B need only be included where an individual is, for the first time, made a director or executive officer of the ultimate controlling person; a director or executive officer terminates his or her responsibilities with the ultimate controlling person; or in the event an individual is named president of the ultimate controlling person.

If a transaction disclosed on the prior year’s annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year’s annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year’s annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.
SIGNATURE AND CERTIFICATION

Pursuant to the requirements of Section 4 of the Act, Registrant has caused this annual registration statement to be duly signed on its behalf of the City of _________________ and State of ______________ on the ____________ day of _____________, 20 ___.

(SEAL)______________________________
Name of Applicant

BY__________________________________
(Name) (Title)

Attest:

________________________________
(Signature of Officer)

________________________________
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached annual registration statement dated ____________, 20____, for and on behalf of _______________________(Name of Applicant); that (s)he is the _________________(Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)______________________________

(Type or print name beneath)______________________________
FORM D

PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Department of the State of ______________________

By

_____________________________________

Name of Registrant

On Behalf of Following Insurance Companies

Name  Address

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

Date: __________________________, 20____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

ITEM 1.    IDENTITY OF PARTIES TO TRANSACTION

Furnish the following information for each of the parties to the transaction:

(a)    Name;

(b)    Home office address;

(c)    Principal executive office address;

(d)    The organizational structure, i.e. corporation, partnership, individual, trust, etc.;

(e)    A description of the nature of the parties’ business operations;

(f)    Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties;

(g)    Where the transaction is with a non-affiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.
ITEM 2. DESCRIPTION OF THE TRANSACTION

Furnish the following information for each transaction for which notice is being given:

(a) A statement as to whether notice is being given under Section 5A(2)(a), (b), (c), (d), or (e) of the Act;

(b) A statement of the nature of the transaction;

(c) A statement of how the transaction meets the 'fair and reasonable' standard of Section 5A(1)(a) of the Act; and

(d) The proposed effective date of the transaction.

ITEM 3. SALES, PURCHASES, EXCHANGES, LOANS, EXTENSIONS OF CREDIT, GUARANTEES OR INVESTMENTS

Furnish a brief description of the amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment, whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice, a description of the terms of any securities being received, if any, and a description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements and the like. If the transaction involves other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

If the transaction involves an investment, guarantee or other arrangement, state the time period during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer’s surplus.

No notice need be given if the maximum amount which can at any time be outstanding or for which the insurer can be legally obligated under the loan, extension of credit or guarantee is less than (a) in the case of non-life insurers, the lesser of 3% of the insurer’s admitted assets or 25% of surplus as regards policyholders, or (b) in the case of life insurers, 3% of the insurer’s admitted assets, each as of the 31st day of December next preceding.

ITEM 4. LOANS OR EXTENSIONS OF CREDIT TO A NON-AFFILIATE

If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of or make investments in any affiliate. Describe the amount and source of funds, securities, property or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer’s surplus.

No notice need be given if the loan or extension of credit is one which equals less than, in the case of non-life insurers, the lesser of 3% of the insurer’s admitted assets or 25% of surplus as regards policyholders or, with respect to life insurers, 3% of the insurer’s admitted assets, each as of the 31st day of December next preceding.
ITEM 5. REINSURANCE

If the transaction is a reinsurance agreement or modification thereto, as described by Section 5A(2)(c)(ii) of the Act, or a reinsurance pooling agreement or modification thereto as described by Section 5A(2)(c)(i) of the Act, furnish a description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement whether an agreement or understanding exists between the insurer and non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer’s affiliates. Furnish a brief description of the consideration involved in the transaction, and a brief statement as to the effect of the transaction upon the insurer’s surplus.

No notice need be given for reinsurance agreements or modifications thereto if the reinsurance premium or a change in the insurer’s liabilities, or the projected reinsurance premium or change in the insurer’s liabilities in any of the next three years, in connection with the reinsurance agreement or modification thereto is less than 5% of the insurer’s surplus as of the 31st day of December next preceding. Notice shall be given for all reinsurance pooling agreements including modifications thereto.

ITEM 6. MANAGEMENT AGREEMENTS, SERVICE AGREEMENTS AND COST-SHARING ARRANGEMENTS.

For management and service agreements, furnish:

(a) A brief description of the managerial responsibilities, or services to be performed;
(b) A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.

For cost-sharing arrangements, furnish:

(a) A brief description of the purpose of the agreement;
(b) A description of the period of time during which the agreement is to be in effect;
(c) A brief description of each party’s expenses or costs covered by the agreement;
(d) A brief description of the accounting basis to be used in calculating each party’s costs under the agreement;
(e) A brief statement as to the effect of the transaction upon the insurer’s policyholder surplus;
(f) A statement regarding the cost allocation methods that specifies whether proposed charges are based on “cost or market.” If market based, rationale for using market instead of cost, including justification for the company’s determination that amounts are fair and reasonable; and
(g) A statement regarding compliance with the NAIC Accounting Practices and Procedure Manual regarding expense allocation.

ITEM 7. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:
SIGNATURE

Pursuant to the requirements of Section 5 of the Act, __________ has caused this application to be duly signed on its behalf in the City of __________ and State of __________ on the __________ day of __________, 20 ___.

(SEAL) __________________________
Name of Applicant

BY _____________________________
(Name) (Title)

Attest:

______________________________
(Signature of Officer)

______________________________
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated __________, 20 ___, for and on behalf of __________ (Name of Applicant); that (s)he is the __________ (Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____________________________

(Type or print name beneath) _____________________________
FORM E

PRE-ACQUISITION NOTIFICATION FORM
REGARDING THE POTENTIAL COMPETITIVE IMPACT
OF A PROPOSED MERGER OR ACQUISITION BY A
NON-DOMICILIARY INSURER DOING BUSINESS IN THIS
STATE OR BY A DOMESTIC INSURER

__________________________
Name of Applicant

__________________________
Name of Other Person
Involved in Merger or
Acquisition

Filed with the Insurance Department of

__________________________

Dated:__________________________, 20__________

Name, title, address and telephone number of person completing this statement:

__________________________

__________________________

__________________________

__________________________

ITEM 1. NAME AND ADDRESS

State the names and addresses of the persons who hereby provide notice of their involvement in a pending acquisition or change in corporate control.

ITEM 2. NAME AND ADDRESSES OF AFFILIATED COMPANIES

State the names and addresses of the persons affiliated with those listed in Item 1. Describe their affiliations.

ITEM 3. NATURE AND PURPOSE OF THE PROPOSED MERGER OR ACQUISITION

State the nature and purpose of the proposed merger or acquisition.

ITEM 4. NATURE OF BUSINESS

State the nature of the business performed by each of the persons identified in response to Item 1 and Item 2.
ITEM 5. MARKET AND MARKET SHARE

State specifically what market and market share in each relevant insurance market the persons identified in Item 1 and Item 2 currently enjoy in this state. Provide historical market and market share data for each person identified in Item 1 and Item 2 for the past five years and identify the source of such data. Provide a determination as to whether the proposed acquisition or merger, if consummated, would violate the competitive standards of the state as stated in Section 3.1D of the Act. If the proposed acquisition or merger would violate competitive standards, provide justification of why the acquisition or merger would not substantially lessen competition or create a monopoly in the state.

For purposes of this question, market means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state.

Drafting Note: State Insurance Departments may additionally choose to make these calculations using their own data or data provided by the National Association of Insurance Commissioners.
FORM F

ENTERPRISE RISK REPORT

Filed with the Insurance Department of the State of ________________________

By

____________________________________

Name of Registrant/Applicant

On Behalf of/Related to Following Insurance Companies

Name  Address

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Date: ______________________, 20____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

______________________________________________________________________________________

______________________________________________________________________________________

ITEM 1. ENTERPRISE RISK

The Registrant/Applicant, to the best of its knowledge and belief, shall provide information regarding the following areas that could produce enterprise risk as defined in [insert cross reference to definition of Enterprise Risk in Section 1F of the Act], provided such information is not disclosed in the Insurance Holding Company System Annual Registration Statement filed on behalf of itself or another insurer for which it is the ultimate controlling person:

- Any material developments regarding strategy, internal audit findings, compliance or risk management affecting the insurance holding company system;
- Acquisition or disposal of insurance entities and reallocating of existing financial or insurance entities within the insurance holding company system;
- Any changes of shareholders of the insurance holding company system exceeding ten percent (10%) or more of voting securities;
- Developments in various investigations, regulatory activities or litigation that may have a significant bearing or impact on the insurance holding company system;
- Business plan of the insurance holding company system and summarized strategies for the next 12 months;
- Identification of material concerns of the insurance holding company system raised by supervisory college, if any, in the last year;

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- Identification of insurance holding company system capital resources and material distribution patterns;

- Identification of any negative movement, or discussions with rating agencies which may have caused, or may cause, potential negative movement in the credit ratings and individual insurer financial strength ratings assessment of the insurance holding company system (including both the rating score and outlook);

- Information on corporate or parental guarantees throughout the holding company and the expected source of liquidity should such guarantees be called upon; and

- Identification of any material activity or development of the insurance holding company system that, in the opinion of senior management, could adversely affect the insurance holding company system.

The Registrant/Applicant may attach the appropriate form most recently filed with the U.S. Securities and Exchange Commission, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the form provides responsive information. If the Registrant/Applicant is not domiciled in the U.S., it may attach its most recent public audited financial statement filed in its country of domicile, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the financial statement provides responsive information.

ITEM 2: OBLIGATION TO REPORT.

If the Registrant/Applicant has not disclosed any information pursuant to Item 1, the Registrant/Applicant shall include a statement affirming that, to the best of its knowledge and belief, it has not identified enterprise risk subject to disclosure pursuant to Item 1.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2013 3rd Quarter (editorial revision).
Fall 2020 (amended).
Receivership Law (E) Working Group

Summary of Comments Received January 29, 2021 on Proposed Revisions to:
Insurance Holding Company System Regulatory Act, Model #440 and Regulation, Model #450

<table>
<thead>
<tr>
<th>Model #440</th>
<th>Section 5.A(1)(g)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACLI</td>
<td>The bond requirement provision would place U.S. insurers at a competitive disadvantage, especially in case of an insolvency. Some may consider turning from affiliates to third parties, which would likely frustrate regulators and make resolution more complex. Furthermore, this is not a standard industry practice. In addition, we do not believe the Drafting Note adequately addresses this issue.</td>
</tr>
<tr>
<td>AHIP &amp; BCBSA</td>
<td>As we review the proposed changes to Model #440, we note with concern the potential solution expressed in Section 5.A(1)(g) which would require all holding companies to post bonds for all affiliate contracts or agreements. There is no mention of any determination of whether the holding company itself or any of its affiliates are in danger of insolvency or otherwise unable to perform their contractual obligations. In the vast majority of cases, insurance holding companies are responsibly regulated and well managed, and neither they nor their affiliates are in jeopardy. This means the practical effect of this broadly applied measure would be to needlessly increase the costs of operation of the holding company without, in most cases, any discernable benefit to the company, the affiliates, or consumers. These resources could be better utilized to provide services which more directly serve the needs of policyholders. This provision also has an implied bias, i.e., that a contract with an affiliate is somehow riskier than the same contract would be with a non-affiliate, or that in the event of an insolvency, a company in receivership is less likely to get cooperation from an affiliate than a non-affiliate. Although we’ve not conducted any in-depth review of historical insolvencies, we submit these premises are unproven, and in fact, that the contrary may well be true. An approach of this nature should certainly include a method for commissioners to clearly delineate those carriers that pose a greater risk of insolvency necessitating bonds for all affiliate contracts or agreements. The NAIC has made significant strides in developing and successfully implementing solvency monitoring tools including, but not limited to, Risk-Focused Financial Analysis and Examination Frameworks and Risk-Based and Group Capital calculations. We believe that regulators have the necessary and essential tools to identify specific carriers who demonstrate hazardous trends and pose a solvency risk which could indicate posting bonds for all affiliate contracts or agreements. We suggest a better approach would be to limit the bonding requirement to a more targeted application, to companies in which there is some objective basis for financial concern. This might be some sort of triggering event or circumstance, perhaps related to periodic financial analysis, risk-based capital submissions, or other similar review. We must oppose any indiscriminately applied bonding requirement that directly penalizes the majority of carriers which are considered well-capitalized, well-governed, and at low risk of insolvency.</td>
</tr>
</tbody>
</table>
Coalition  As we noted in our earlier comment letter of September 24, 2020, the coalition members agree that it is important to protect consumers in the event of a rehabilitation or receivership. We recognize the challenges that face receivers in these instances and support amendments that would bolster a receiver’s ability to protect the public. It is important, however, that these amendments do not, at the same time, harm consumers who are members of financially stable, ongoing concerns.

The proposed amendments to Model #440, *Insurance Holding Company System Regulatory Act*, will make far-reaching changes to the operations of holding companies, far beyond the receivership or rehabilitation arena. Every holding company, whether it is deemed to be at risk or not, will be required to post a bond for *all* affiliate contracts or agreements of an unknown, and unknowable, amount (Sec. 5.A.(a)(g)), they will be required to maintain separate accounts under certain circumstances (Sec. 5.A.(a)(i)), and are required to subject themselves to a potentially unknown and unknowable state court jurisdiction.

We suggest that these provisions, in particular the bonding requirement, are unwise for a number of reasons. First, in the health insurance arena, the environmental trend has long been toward health and wellness integration. Health insurers of any size that are part of a holding company system have and will continue to move toward a more integrated business model that provides not only better health and wellness but also synergies and centralized functions. Centralized functions not only provide policyholders, clients and owners a benefit of scale but streamline insurer operations. Suggesting that every affiliate contract, regardless whether it is material, whether it is critical to the continued operations of the legal entity, or whether it is more or less likely to be necessary to the operations of a receiver, be subject to a bond is a blunt instrument that creates barriers for health carriers to provide services to their members and policyholders, and raises costs and complexity. Health carriers by their very nature have multiple subsidiaries and affiliates. There is a very real chilling effect that the financial burden of a potentially unlimited bonding requirement will have on health insurance operations. Simply the cost of monitoring and maintaining appropriate bonding requirements is a significant cost to companies for very little return and will provide no health or wellness benefits to our consumers to justify such a significant operational cost.

Second, the bonding requirement is unknown and unknowable, and bears no relation to the importance of the services to the operation, the riskiness of the business or the insurer, and ultimately, provides no benefits to policyholders or consumers. There is no reason to place this potentially unlimited and burdensome requirement on a solvent, ongoing operation and the consumers that it serves. Receivers have access to many tools during the course of an insolvency. This one is overly draconian and unnecessary. If a bond is necessary, then it should be necessary for all contracts, not just those with affiliates. We suggest that non-affiliate, third-party contracts are significantly more risky than those within an insurance holding company system.

Third, the requirement that every affiliate contract be subject to a bond is, in effect, an economic tax on integration. A regulatory scheme that favors non-integrated, free-standing licenses that outsource all relevant operations to external contracts is misguided. Those non-integrated services provided by non-integrated contracts are more, not less risky to the operations of an enterprise, yet this provision penalizes insurers for developing the more rational, Safe business model. If a health insurer uses an affiliate to provide payment integrity services, there is less, not more risk to the insurer and its consumers than if those
Services were provided by an outside contractor with no affiliation to the holding company system. The purpose of creating integrated groups is precisely to have better control, and better economics for the enterprise. There is no reason the regulatory community should attempt to disincentivize these operations that provide significant savings and benefits to members and policyholders.

Florida

(g) The insurer shall require the affiliated person(s) to obtain and maintain a bond for the protection of the insurer for the duration of the contract or agreement as required by the commissioner at any time. The bond amount should be no less than the amount specified by the commissioner and noncancelable or terminated by supervision, seizure, conservatorship, or receivership pursuant to [supervision and receivership acts].

Section 5.A.(1)(h)

ACLI Our initial concerns on the segregation provision were properly addressed in the proposed revisions. However, we believe the last two sentences of the subsection may be impractical as counterparties are unlikely to give insurers access to their systems; affiliates are unlikely to waive legal rights on a prospective basis; and affiliates may not be able to waive their rights if they are acting on behalf of a client.

Florida

(h) All records and data of the insurer held by an affiliate are and remain the property of the insurer, are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation, at no cost to the insurer, from all other persons’ records and data.

Morgan Lewis

The Act Amendments and the Regulation Amendment proceed on the basis that the books, records and data held by the affiliate are property of the insurer, with the apparent expectation that the receiver can simply take possession and control of them to the exclusion of the affiliates and thereby conduct the affairs of the insurer. Using the term “property” would suggest that the affiliate would need to surrender possession and control of all the data, which is likely infeasible and probably undesirable. Instead, a more detailed approach should be considered. Moreover, the notion that data could and should be readily capable of segregation and that passwords, software and other information” must be available to the insurer is likely to defeat the legitimate business purposes served by locating certain operations in affiliates and put the affiliate, insurer, third-parties and regulators at risk of violating data privacy laws. Changes to the model act and regulation should provide that the receiver can obtain a complete set of all records of any type that pertain to the insurer’s business; obtain access to the operating systems on which the data is maintained; obtain the software that runs those systems either through assumption of licensing agreements or otherwise; and restrict the use of the data by the affiliate if it is not operating the insurer’s business.

Section 5.A.(1)(i)

ACLI This subsection appears to expand upon existing regulations related to an insurer’s funds. The prohibition on comingling is unlikely impractical (e.g., if the affiliate is managing a joint venture on behalf of the insurer).

AHIP & BCBSA Additionally, we share the concerns expressed in the Coalition of Health Insurers’ comment letter pertaining to Section 5.A(1)(i)’s requirement that the insurer’s funds not be commingled with any other accounts. We agree that any such funds, premiums or otherwise, should be clearly and easily identified in the books, accounts, and records of the
affiliate, as required in Section 5.A(1)(e), but we believe clarification would be helpful in 
what else should be done to increase the clarity and ability to identify the various funds’ 
ownership.

| Coalition | In addition to objections to the bonding requirements, we question the language in Sec. 
| 5.A.(1)(i) that “premiums or other funds belonging to the insurer” in the hands of an 
affiliate may not be commingled. It is unclear what “other funds belonging to the insurer” 
may include. While we agree that premiums collected by a third party, whether affiliated or 
not, should be clearly identified as belonging to the insurer on whose behalf they are 
collected, we request clarification about what other “funds” are included in this provision. 
We also suggest that Section 5 already requires that “the books, accounts and records of 
each party...shall be so maintained as to clearly and accurately disclosure the nature and 
details of the transactions...” We question whether this new language in paragraph (i) is 
necessary. |

| Morgan Lewis | The Act Amendments and the Regulation Amendment establish ownership of premiums in 
the hands of the affiliate and in most circumstances require the affiliate to perform services 
without being paid for prior services, at least for a limited period. While this may seem 
desirable from the perspective of the regulator, it is likely not. The affiliates are often 
highly dependent on the revenues from the operation of the insurer, in order to carry out 
the business of the insurer. In particular, the affiliate may be responsible for the payment 
of an insurer’s claims. As the amendments are currently drafted, it is not clear that the 
regulator is required to perform the insurer’s obligation as provided by the agreements. 
There have been recent instances in which regulators have refused to honor agreements 
with the affiliates after taking control of the insurer (and even in supervision), and 
unilaterally imposed alternative arrangements that ultimately resulted in the failure of the 
affiliates. If it is not clear that the regulator is required to follow the agreements with 
affiliates, affiliates will need to seek bankruptcy protection to reject the agreements, which 
in turn will lead to an unproductive standoff with the regulators. 

Additionally, due consideration should be given to the impact of this proposal on other 
laws, particularly those relating to producers’ obligations. 

The same applies to premium. If the contracts provide that the affiliate collects premium 
and sets off its fees prior to remitting the premium to the insurer, disturbing that 
arrangement guaranties that the affiliate will fail and the regulator will wind up with no 
services. The amendments are not clear as to whether the rights being established eliminate 
the contractual setoff rights. If it is going to overturn setoff rights, that should be made 
explicit since it changes the law in receivership, which in most cases expressly recognizes 
set off rights. At a minimum, this should be made clear one way or the other so that all 
parties understand what to expect. However, if the rights are eliminated, the regulatory 
community should expect that holding company systems will seek bankruptcy protection 
very early in the process so that they are protected from unilateral action by regulators. |

| ACLI | We question how this subsection might handle certain situations where affiliates 
agreements are governed by multiple supervisors or jurisdictions, or the affiliates do not 
accept the selected jurisdiction for supervision, seizure, conservatorship, or receivership 
proceedings. Often, insurers and affiliates select specific jurisdictions based on the 
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<td>Section 19B(7)</td>
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COMMENTS FROM FLORIDA

M440

Section 5. A. (1)

(g) The insurer shall require the affiliated person(s) to obtain and maintain a bond for the protection of the insurer for the duration of the contract or agreement as required by the commissioner at any time. The bond amount should be no less than the amount specified by the commissioner and noncancelable or terminated by supervision, seizure, conservatorship, or receivership pursuant to supervision and receivership acts.

(h) All records and data of the insurer held by an affiliate are and remain the property of the insurer, are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation, at no cost to the insurer, from all other persons’ records and data. This includes all records and data that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate. At the request of the insurer, the affiliate shall make all records and data related to the insurer available for inspection, and shall provide the insurer with any login instructions, passwords, software or other information necessary to obtain access to the records and data. The affiliate shall provide a waiver of any landlord lien or other encumbrance to giving the insurer access to all records and data in the event of the affiliate’s default under a lease or other agreement; and,

MO450

Section 19. B.

(7) Specify that all records and data of the insurer are and remain the property of the insurer, are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation, at no cost to the insurer, from all other persons records and data;
Wayne Mehlman  
Senior Counsel  

January 29, 2021  

Kevin Baldwin, Co-Chair  
Laura Lyon Slaymaker, Co-Chair  
Receivership Law (E) Working Group  
National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
Kansas City, MO 64108  

RE: Proposed Amendments to the Insurance Holding Company System Regulatory Act (#440)  
and the Insurance Holding Company System Model Regulation (#450)  

Dear Co-Chairs Baldwin and Slaymaker:  

The American Council of Life Insurers (“ACLI”) appreciates this opportunity to provide comments  
to the Receivership Law Working Group on proposed amendments to Models #440 and #450 relating  
to the continuity of essential services and functions through affiliated intercompany agreements  
during an insurer receivership.  

While we support most of the proposed amendments, we believe that some of them would either be  
extremely burdensome for insurers and their affiliates, or simply impractical.  

Below are the concerns we have with regard to Model #440:  

Section 5.A.(1)(g) - The bond requirement provision would place U.S. insurers at a competitive  
disadvantage, especially in case of an insolvency. Some may consider turning from affiliates to third-  
parties, which would likely frustrate regulators and make resolution more complex. Furthermore, this  
is not a standard industry practice. In addition, we do not believe the Drafting Note adequately  
dresses this issue.  

Section 5.A.(1)(h) - Our initial concerns on the segregation provision were properly addressed in the  
proposed revisions. However, we believe the last two sentences of the subsection may be impractical  
as counterparties are unlikely to give insurers access to their systems; affiliates are unlikely to waive  
legal rights on a prospective basis; and affiliates may not be able to waive their rights if they are  
acting on behalf of a client.  

1 The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and  
avocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance  
industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting  
consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance,  
disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280  
member companies represent 95 percent of industry assets in the United States. Learn more at www.acli.com.

American Council of Life Insurers  
101 Constitution Avenue, NW, Washington, DC 20001-2133  
(202) 624-2135 waynemehlman@acli.com  

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Section 5.A.(1)(i) - This subsection appears to expand upon existing regulations related to an insurer’s funds. The prohibition on comingling is unlikely impractical (e.g., if the affiliate is managing a joint venture on behalf of the insurer.

Section 5.A.(6) – We question how this subsection might handle certain situations where affiliates agreements are governed by multiple supervisors or jurisdictions, or the affiliates do not accept the selected jurisdiction for supervision, seizure, conservatorship, or receivership proceedings. Often, insurers and affiliates select specific jurisdictions based on the agreement (e.g., investment agreements are often done in New York because their law and courts are most developed). How would this subsection address service agreements between two affiliated insurers with different supervisors and jurisdictions? What about foreign affiliates who are outside the jurisdiction of the U.S.?

Section 11.D. – We believe that having to put in place a bond for any agreement found not to have been properly approved would be very punitive. Insurers usually just seek regulatory approval after the fact.

Below are the concerns we have with regard to Model #450:

Section 19.B.(6), Section 19.B.(11)(b) and (c), Section 19.B.(13): It is not reasonable to ask the affiliate to do work for at no cost, and the requirements will be problematic for regulated entities and those in bankruptcy.

Thanks again for this opportunity to comment. If you have any questions, feel free to contact me at waynemehlman@aci.com or 202-624-2135.

Sincerely,

Wayne Mehlman
Senior Counsel, Insurance Regulation
January 29, 2021

Kevin Baldwin, Co-Chair
Laura Lyon Slaymaker, Co-Chair
Receivership Law (E) Working Group
National Association of Insurance Commissioners

Via e-mail to Jane Koenigsman:  jkoenigsman@naic.org

Re: “Essential Services” and Models #440 and #450

Dear Ms. Slaymaker and Mr. Baldwin;

America’s Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA) appreciate this opportunity to comment on the Receivership Law (E) Working Group’s proposed revisions to the Insurance Holding Company System Regulatory Act, Model #440 and the companion Regulation, Model #450.

As we review the proposed changes to Model #440, we note with concern the potential solution expressed in Section 5.A(1)(g) which would require all holding companies to post bonds for all affiliate contracts or agreements. There is no mention of any determination of whether the holding company itself or any of its affiliates are in danger of insolvency or otherwise unable to perform their contractual obligations. In the vast majority of cases, insurance holding companies are responsibly regulated and well managed, and neither they nor their affiliates are in jeopardy. This means the practical effect of this broadly applied measure would be to needlessly increase the costs of operation of the holding company without, in most cases, any discernable benefit to the company, the affiliates, or consumers. These resources could be better utilized to provide services which more directly serve the needs of policyholders.

This provision also has an implied bias, i.e., that a contract with an affiliate is somehow riskier than the same contract would be with a non-affiliate, or that in the event of an insolvency, a company in receivership is less likely to get cooperation from an affiliate than a non-affiliate.
Although we’ve not conducted any in-depth review of historical insolvencies, we submit these premises are unproven, and in fact, that the contrary may well be true.

An approach of this nature should certainly include a method for commissioners to clearly delineate those carriers that pose a greater risk of insolvency necessitating bonds for all affiliate contracts or agreements. The NAIC has made significant strides in developing and successfully implementing solvency monitoring tools including, but not limited to, Risk-Focused Financial Analysis and Examination Frameworks and Risk-Based and Group Capital calculations. We believe that regulators have the necessary and essential tools to identify specific carriers who demonstrate hazardous trends and pose a solvency risk which could indicate posting bonds for all affiliate contracts or agreements.

We suggest a better approach would be to limit the bonding requirement to a more targeted application, to companies in which there is some objective basis for financial concern. This might be some sort of triggering event or circumstance, perhaps related to periodic financial analysis, risk-based capital submissions, or other similar review. We must oppose any indiscriminately applied bonding requirement that directly penalizes the majority of carriers which are considered well-capitalized, well-governed, and at low risk of insolvency.

Additionally, we share the concerns expressed in the Coalition of Health Insurers’ comment letter pertaining to Section 5.A(1)(i)’s requirement that the insurer’s funds not be commingled with any other accounts. We agree that any such funds, premiums or otherwise, should be clearly and easily identified in the books, accounts, and records of the affiliate, as required in Section 5.A(1)(e), but we believe clarification would be helpful in what else should be done to increase the clarity and ability to identify the various funds’ ownership.

Again, AHIP and BCBSA appreciate this opportunity to offer comments on this issue, and we look forward to working with you to find the most productive way forward.

Sincerely,

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Bridgeway@AHIP.org
501-333-2621

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Director, Financial Regulatory Services
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Chris Petersen
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January 29, 2021

Mr. Kevin Baldwin
Illinois Department of Insurance
State of Illinois
320 W. Washington St., 4th Floor
Springfield, Illinois 62767-0001

Ms. Laura Lyon Slaymaker
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, Pennsylvania 17120

Via email to Jane Koenigsman, NAIC

Re: Amendments to Models #440/450

Dear Mr. Baldwin and Ms. Slaymaker:

I write on behalf of a coalition of health insurance companies, including Anthem, Cigna, CVS Health and UnitedHealth Group, who thank you for the opportunity to provide additional comments regarding the continuation of essential services through affiliated intercompany agreements for insurers in receivership. As we noted in our earlier comment letter of September 24, 2020, the coalition members agree that it is important to protect consumers in the event of a rehabilitation or receivership. We recognize the challenges that face receivers in these instances and support amendments that would bolster a receiver’s ability to protect the public. It is important, however, that these amendments do not, at the same time, harm consumers who are members of financially stable, ongoing concerns.

The proposed amendments to Model #440, the Insurance Holding Company System Regulatory Act, will make far-reaching changes to the operations of holding companies, far beyond the receivership or rehabilitation arena. Every holding company, whether it is deemed to be at risk or not, will be required to post a bond for all affiliate contracts or agreements of an unknown, and unknowable, amount (Sec. 5.A.(a)(g)), they will be required to maintain separate accounts under...
certain circumstances (Sec. 5.A.(a)(i)), and are required to subject themselves to a potentially unknown and unknowable state court jurisdiction.

We suggest that these provisions, in particular the bonding requirement, are unwise for a number of reasons. First, in the health insurance arena, the environmental trend has long been toward health and wellness integration. Health insurers of any size that are part of a holding company system have and will continue to move toward a more integrated business model that provides not only better health and wellness but also synergies and centralized functions. Centralized functions not only provide policyholders, clients and owners a benefit of scale but streamline insurer operations. Suggesting that every affiliate contract, regardless whether it is material, whether it is critical to the continued operations of the legal entity, or whether it is more or less likely to be necessary to the operations of a receiver, be subject to a bond is a blunt instrument that creates barriers for health carriers to provide services to their members and policyholders, and raises costs and complexity. Health carriers by their very nature have multiple subsidiaries and affiliates. There is a very real chilling effect that the financial burden of a potentially unlimited bonding requirement will have on health insurance operations. Simply the cost of monitoring and maintaining appropriate bonding requirements is a significant cost to companies for very little return and will provide no health or wellness benefits to our consumers to justify such a significant operational cost.

Second, the bonding requirement is unknown and unknowable, and bears no relation to the importance of the services to the operation, the riskiness of the business or the insurer, and ultimately, provides no benefits to policyholders or consumers. There is no reason to place this potentially unlimited and burdensome requirement on a solvent, ongoing operation and the consumers that it serves. Receivers have access to many tools during the course of an insolvency. This one is overly draconian and unnecessary. If a bond is necessary, then it should be necessary for all contracts, not just those with affiliates. We suggest that non-affiliate, third-party contracts are significantly more risky than those within an insurance holding company system.

Third, the requirement that every affiliate contract be subject to a bond is, in effect, an economic tax on integration. A regulatory scheme that favors non-integrated, free-standing licenses that outsource all relevant operations to external contracts is misguided. Those non-integrated services provided by non-integrated contracts are more, not less risky to the operations of an enterprise, yet this provision penalizes insurers for developing the more rational, safe business model. If a health insurer uses an affiliate to provide payment integrity services, there is less, not more risk to the insurer and its consumers than if those services were provided by an outside contractor with no affiliation to the holding company system. The purpose of creating integrated groups is precisely to have better control, and better economics for the enterprise. There is no reason the regulatory community should attempt to disincentivize these operations that provide significant savings and benefits to members and policyholders.

In addition to objections to the bonding requirements, we question the language in Sec. 5.A.(1)(i) that “premiums or other funds belonging to the insurer” in the hands of an affiliate may not be commingled. It is unclear what “other funds belonging to the insurer” may include. While we agree that premiums collected by a third party, whether affiliated or not, should be clearly
Arbor Strategies, LLC  
January 29, 2021  
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identified as belonging to the insurer on whose behalf they are collected, we request clarification about what other “funds” are included in this provision. We also suggest that Section 5 already requires that “the books, accounts and records of each party…shall be so maintained as to clearly and accurately disclose the nature and details of the transactions…” We question whether this new language in paragraph (i) is necessary.

We thank you for the opportunity to provide our comments on these amendments and look forward to continued discussions with the Working Group.

Sincerely yours,

Chris Petersen  
Arbor Strategies, LLC

Cc: Jane Koenigsman
January 29, 2021

VIA E-MAIL

Jane Koenigsman
Sr. Manager - Life/Health Financial Analysis
National Association of Insurance Commissioners (NAIC)
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

Re: Comments on Amendments to Holding Company Acts

Dear Jane:

We write to comment on the attached amendments to Sections 5 and 11 of the Insurance Holding Company System Regulatory Act (#440) and Section 19 of the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). The proposed amendments strengthen the regulator's hand in dealing with the now common situation where an insurance company's operating functions are distributed around the members of a holding company group.

1. The Act Amendments and the Regulation Amendment proceed on the basis that the books, records and data held by an affiliate are property of the insurer, with the apparent expectation that the receiver can simply take possession and control of them to the exclusion of the affiliates and thereby conduct the affairs of the insurer. Using the term "property" would suggest that the affiliate would need to surrender possession and control of all the data, which is likely infeasible, and probably undesirable. Instead, a more detailed approach should be considered. Moreover, the notion that data could or should be "readily capable of segregation" and that "passwords, software or other information" must be available to the insurer is likely to defeat the legitimate business purposes served by locating certain operations in affiliates and put the affiliate, insurer, third-parties and regulators at risk of violating data privacy laws. Changes to the model act and regulation should provide that the receiver can obtain a complete set of all records of any type that pertain to the insurer's business; obtain access to the operating systems on which the data is maintained; obtain the software that runs those systems either through assumption of licensing agreements or otherwise; and restrict the use of the data by the affiliate if it is not operating the insurer's business.

2. The Act Amendments and the Regulation Amendment establish ownership of premiums in the hands of the affiliate and in most circumstances require the affiliate to perform services without being paid for prior services, at least for a limited period. While this may seem desirable from the perspective of the regulator, it is likely not. The affiliates are often highly dependent on
the revenues from the operation of the insurer, in order to carry out the business of the insurer. In particular, the affiliate may be responsible for the payment of an insurer’s claims. As the amendments are currently drafted, it is not clear that the regulator is required to perform the insurer's obligation as provided by the agreements. There have been recent instances in which regulators have refused to honor agreements with the affiliates after taking control of the insurer (and even in supervision), and unilaterally imposed alternative arrangements that ultimately resulted in the failure of the affiliates. If it is not clear that the regulator is required to follow the agreements with affiliates, affiliates will need to seek bankruptcy protection to reject the agreements, which in turn will lead to an unproductive standoff with the regulators.

Additionally, due consideration should be given to the impact of this proposal on other laws, particularly those relating to producers’ obligations.

3. The same applies to premium. If the contracts provide that the affiliate collects premium and sets off its fees prior to remitting the premium to the insurer, disturbing that arrangement guaranties that the affiliate will fail and the regulator will wind up with no services. The amendments are not clear as to whether the rights being established eliminate the contractual setoff rights. If it is going to over turn setoff rights, that should be made explicit since it changes the law in receivership, which in most cases expressly recognizes set off rights. At a minimum, this should be made clear one way or the other so that all parties understand what to expect. However, if the rights are eliminated, the regulatory community should expect that holding company systems will seek bankruptcy protection very early in the process so that they are protected from unilateral action by regulators.

Sincerely,

Harold S. Horwich

HSH/vgd
Enclosures
NOLHGA and NCIGF provide the following comments in response to the exposure of draft amendments to Models #440 and #450 ("Draft Amendments") for public comment on December 18, 2020. NOLHGA and NCIGF appreciate the Working Group's consideration of their comments submitted on December 16, 2020, and believe the Draft Amendments as presented for public comment reflect those comments.

NOLHGA and NCIGF offer technical suggestions for the Working Group's consideration.

Model #450 Section 19B(15)

During its call on December 17, 2020, the Working Group discussed the importance of early coordination between the receiver and the affected guaranty association(s) and noted that such coordination is necessary even before a guaranty association is triggered (e.g., during supervision or conservatorship). The Working Group decided to include the new Section 19B(15) suggested by NOLHGA and NCIGF. In response to a question from an interested party and discussion among the Working Group, the proposed language was modified to reflect the concept of early coordination between the receiver and the affected guaranty association(s).

NOLHGA and NCIGF generally agree with the modifications made to the new Section 19B(15). We offer the following technical changes for consistency. Since this Section contemplates cooperation prior to guaranty association triggering, we recommend referring to policies or contracts that are "eligible for coverage." Referring to policies or contracts that are "covered" could imply that coverage determinations have been made, which would not be the case in supervision, conservation, or otherwise before a guaranty association is triggered.

Specify that, in furtherance of the cooperation between the receiver and the affected guaranty association(s) and subject to the receiver's authority over the insurer, if the insurer is placed into supervision, seizure, conservatorship, or receivership pursuant to [supervision and receivership acts], and portions of the insurer's policies or contracts are covered eligible for coverage by one or more guaranty associations, the affiliate's commitments under Subsections 19B(11), 19B(12), 19B(13) and 19B(14) of this regulation will extend to the such guaranty association(s) providing such coverage.

****

We appreciate your consideration of this proposed change, and we look forward to contributing to the Working Group's continued discussions.
Contact Information

National Organization of Life and Health Insurance Guaranty Associations  
13873 Park Center Road, Suite 505  
Herndon, VA 20171  
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National Conference of Insurance Guaranty Funds  
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Roger H. Schmelzer  
President  
E-Mail: rschmelzer@ncigf.org
February 26, 2021

Kevin Baldwin, Co-Chair  
Laura Lyon Slaymaker, Co-Chair  
Receivership Law (E) Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street  
Suite 1500  
Kansas City, MO 64106-2197  

Dear Co-Chairs Baldwin and Slaymaker:

The American Property Casualty Insurance Association (APCIA) takes this opportunity to offer comments on the proposed amendments to Model #440 relating to the continuity of essential services and functions through affiliated intercompany agreements during an insurer receivership.

Section 5A(g) gives the commissioner the discretion to direct an insurer to require a bond of an affiliated service provider but places no limits whatsoever on the commissioner’s discretion. The Working Group has proposed some new language in the drafting note setting forth the types of things the commissioner should consider in deciding whether and how to exercise the discretion to require a bond. APCIA believes the proposed drafting note language is helpful and we support its inclusion. However, APCIA believes that an additional amendment is needed to the text of Section 5A(g) itself to clarify that the amount of the bond required may not exceed the value of the contract(s) or agreement(s) in any one year. We therefore propose that the language be amended as follows:

(g) The insurer shall require the affiliated person(s) to obtain and maintain a bond for the protection of the insurer for the duration of the contract(s) or agreement(s) if required at the discretion of the commissioner at any time. The bond amount should be no less than the amount specified by the commissioner, which amount shall not exceed the value of the contract(s) or agreement(s) in any one year.

APCIA believes this should provide adequate protection to the insurer or receiver while ensuring that the bond requirement will not be excessive and unreasonably burdensome.

APCIA appreciates the Working Group’s consideration of this proposed addition and we would be pleased to respond to any questions or concerns Working Group members may have.

Sincerely,

Robert W. Woody
VIA EMAIL

Mr. Kevin Baldwin
Illinois Department of Insurance
State of Illinois
320 W. Washington St., 4th Floor
Springfield, Illinois 62767-0001

Ms. Laura Lyon Slaymaker
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, Pennsylvania 17120

Via email to Jane Koenigsman, NAIC

Re: Amendments to Model 440

Dear Mr. Baldwin and Ms Slaymaker:

I write on behalf of a coalition of health insurance companies, including Anthem, Cigna, CVS Health and UnitedHealth Group, who thank you for the opportunity to provide comments regarding the revised amendments to the Insurance Holding Company System Regulatory Act (“Model 440”) that the Receivership Law Working Group (“Working Group”) recently exposed. As noted in our earlier comment letters, the coalition members agree that it is important to protect consumers in the event of a rehabilitation or receivership. We recognize the challenges receivers face in these instances and support amendments that would bolster a receiver’s ability to protect the public. It is important, however, that these amendments do not, at the same time, harm consumers who are members of financially stable, ongoing concerns. Unfortunately, the revised language regarding bonding requirements do exactly that.

As we noted in greater detail in our letter dated January 29, 2021 (attached) imposing bonding requirements on stable, solvent health insurance groups places unnecessary financial burdens on the insurers and their members through increased premiums to finance these
unnecessary bonding requirements. The provisions of the latest draft, which grant the state the unfettered discretion to impose any bond requirement at any time, in any amount, for any reason or for no reason, are unwise for a number of reasons. First, they do not recognize that the environment in the health insurance arena has long been toward health and wellness integration. Allowing the state to impose a bond requirement on internally integrated health care systems creates a perverse incentive for carriers to unwind their integration and avoid the potentially extreme bond cost requirements. This is, in effect, a regulatory tax on integration in the health care system.

Second, the bond requirement is unknown and unknowable, and bears no relation to the importance of the services to the operation, the riskiness of the business or the insurer, and ultimately, for the vast majority of insurers subject to these provisions, provides no benefits to policyholders or consumers. It will, however, create layers of costs that will ultimately be borne by those policyholders. As the U.S. regulatory system attempts to move toward a more risk-based solvency oversight system, it makes no sense to create a potentially massive financial requirement that has no rational basis in the risk posed by an enterprise. In addition, leaving the requirement completely to the discretion of insurance commissioners will necessarily result in uneven application and politicize the bonding requirements. Finally, the proposed amendment does not address the central issue of how to ensure that there are proper tools in place for receivers to address concerns with financially distress companies.

To the extent that bonding requirements remain in Model 440, we believe that the discretion to impose these requirements should be based on solvency triggers. The use of a solvency trigger ensures that the bonding requirements are only imposed on those insurers where additional protections are needed. Additionally, the use of solvency triggers also ensures that the bonding requirements are imposed at the point in time when additional protections are warranted. We recommend the following language as a better alternative as to when bonding requirements should be implemented:

(g) If an insurer subject to this Act is deemed to be in a hazardous financial condition as defined by [insert citation for Model Regulation to Define Standards and Commissioner’s Authority for Companies Deemed to be in Hazardous Financial Condition] or a condition that would be grounds for supervision, conservation, or a delinquency proceeding, then the Commissioner may require the insurer or the affiliated person(s) to obtain and maintain a bond for the protection of the insurer for the duration of the contract(s) or agreement(s). The bond amount should be no less than the amount specified by the commissioner;

We also recommend that the NAIC amend the proposed draft noting at page 440-17 regarding the bonding requirements as follows:

**Drafting Note:** The bond requirement is at the discretion of the commissioner. The intent of the bond is to ensure the affiliated services provided under the contract(s) are fulfilled, which may be referred to as a “performance bond”. In determining appropriate circumstances when a commissioner may require a bond and in specifying an amount, the
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commissioner should evaluate and consider whether an insurer subject to this act is in a hazardous financial condition or a condition that would be grounds for substantial regulatory action including supervision, conservation, or a delinquency proceeding. If it is, the bond requirement would be available as an additional regulatory remedy at the discretion of the commissioner, their review of the contract and the affiliated person, analysis of the holding company system, and examination or investigation of the insurer to determine whether concerns exist currently or prospectively that warrant such a bond. For example, the commissioner may consider whether concerns exist with respect to the affiliated person’s ability to fulfill the contract or agreement if the insurer is placed into liquidation.

The commissioner also has discretion to determine if a bond is necessary and if so, if it should be required for a single contract, multiple contracts, or contracts with a specific affiliated person rather than requiring bonds for each contract or agreement. Note that bonds under Section 5A(g) may not be needed in states that already require bonds for licensure of third-party administrators.

We thank you for the opportunity to provide our comments and look forward to continued discussions with the Working Group.

Sincerely,

Chris Petersen  
Arbor Strategies, LLC

cc: Jane Koenigsman
Arbor Strategies, LLC

Chris Petersen
804-916-1728
cpetersen@arborstrategies.com

January 29, 2021

Mr. Kevin Baldwin
Illinois Department of Insurance
State of Illinois
320 W. Washington St., 4th Floor
Springfield, Illinois 62767-0001

Ms. Laura Lyon Slaymaker
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, Pennsylvania 17120

Via email to Jane Koenigsman, NAIC

Re: Amendments to Models #440/450

Dear Mr. Baldwin and Ms. Slaymaker:

I write on behalf of a coalition of health insurance companies, including Anthem, Cigna, CVS Health and UnitedHealth Group, who thank you for the opportunity to provide additional comments regarding the continuation of essential services through affiliated intercompany agreements for insurers in receivership. As we noted in our earlier comment letter of September 24, 2020, the coalition members agree that it is important to protect consumers in the event of a rehabilitation or receivership. We recognize the challenges that face receivers in these instances and support amendments that would bolster a receiver’s ability to protect the public. It is important, however, that these amendments do not, at the same time, harm consumers who are members of financially stable, ongoing concerns.

The proposed amendments to Model #440, the Insurance Holding Company System Regulatory Act, will make far-reaching changes to the operations of holding companies, far beyond the receivership or rehabilitation arena. Every holding company, whether it is deemed to be at risk or not, will be required to post a bond for all affiliate contracts or agreements of an unknown, and unknowable, amount (Sec. 5.A.(a)(g)), they will be required to maintain separate accounts under

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certain circumstances (Sec. 5.A.(a)(i)), and are required to subject themselves to a potentially unknown and unknowable state court jurisdiction.

We suggest that these provisions, in particular the bonding requirement, are unwise for a number of reasons. First, in the health insurance arena, the environmental trend has long been toward health and wellness integration. Health insurers of any size that are part of a holding company system have and will continue to move toward a more integrated business model that provides not only better health and wellness but also synergies and centralized functions. Centralized functions not only provide policyholders, clients and owners a benefit of scale but streamline insurer operations. Suggesting that every affiliate contract, regardless whether it is material, whether it is critical to the continued operations of the legal entity, or whether it is more or less likely to be necessary to the operations of a receiver, be subject to a bond is a blunt instrument that creates barriers for health carriers to provide services to their members and policyholders, and raises costs and complexity. Health carriers by their very nature have multiple subsidiaries and affiliates. There is a very real chilling effect that the financial burden of a potentially unlimited bonding requirement will have on health insurance operations. Simply the cost of monitoring and maintaining appropriate bonding requirements is a significant cost to companies for very little return and will provide no health or wellness benefits to our consumers to justify such a significant operational cost.

Second, the bonding requirement is unknown and unknowable, and bears no relation to the importance of the services to the operation, the riskiness of the business or the insurer, and ultimately, provides no benefits to policyholders or consumers. There is no reason to place this potentially unlimited and burdensome requirement on a solvent, ongoing operation and the consumers that it serves. Receivers have access to many tools during the course of an insolvency. This one is overly draconian and unnecessary. If a bond is necessary, then it should be necessary for all contracts, not just those with affiliates. We suggest that non-affiliate, third-party contracts are significantly more risky than those within an insurance holding company system.

Third, the requirement that every affiliate contract be subject to a bond is, in effect, an economic tax on integration. A regulatory scheme that favors non-integrated, free-standing licenses that outsource all relevant operations to external contracts is misguided. Those non-integrated services provided by non-integrated contracts are more, not less risky to the operations of an enterprise, yet this provision penalizes insurers for developing the more rational, safe business model. If a health insurer uses an affiliate to provide payment integrity services, there is less, not more risk to the insurer and its consumers than if those services were provided by an outside contractor with no affiliation to the holding company system. The purpose of creating integrated groups is precisely to have better control, and better economics for the enterprise. There is no reason the regulatory community should attempt to disincentivize these operations that provide significant savings and benefits to members and policyholders.

In addition to objections to the bonding requirements, we question the language in Sec. 5.A.(1)(i) that “premiums or other funds belonging to the insurer” in the hands of an affiliate may not be commingled. It is unclear what “other funds belonging to the insurer” may include. While we agree that premiums collected by a third party, whether affiliated or not, should be clearly
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identified as belonging to the insurer on whose behalf they are collected, we request clarification about what other “funds” are included in this provision. We also suggest that Section 5 already requires that “the books, accounts and records of each party...shall be so maintained as to clearly and accurately disclosure the nature and details of the transactions...” We question whether this new language in paragraph (i) is necessary.

We thank you for the opportunity to provide our comments on these amendments and look forward to continued discussions with the Working Group.

Sincerely yours,

Chris Petersen
Arbor Strategies, LLC

Cc: Jane Koenigsman
February 26, 2021

Kevin Baldwin, Co-Chair
Laura Lyon Slaymaker, Co-Chair
Receivership Law (E) Working Group
National Association of Insurance Commissioners

Via e-mail to Jane Koenigsman: jkoenigsman@naic.org

Re: “Essential Services” and Models #440 and #450

Dear Mr. Baldwin and Ms. Slaymaker;

America’s Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA)
welcome the opportunity to comment on the Receivership Law (E) Working Group’s revised and
proposed revisions to the Insurance Holding Company System Regulatory Act, Model #440, re-exposed
for comments on Feb. 4.

We appreciate the Working Group’s continued efforts and deliberative process to find feasible solutions
that are satisfactory to all interested stakeholders. Our comments are focused on the proposed revisions in
Section 5.A(1)(g), that would “require the affiliated person(s) to obtain and maintain a bond for the
protection of the insurer for the duration of the contract(s) or agreement(s) if required at the discretion of
the commissioner at any time.”

As noted in our Jan. 29 comment letter, we recommend that a better approach would be to limit the bonding
requirement to a more targeted application, specifically for insurers in which there is some objective basis
for receivership concern and a triggering event or circumstance. Following is suggested language that we
propose for the working group’s consideration.

If an insurer subject to this Act is deemed to be in a hazardous financial condition as defined by [insert
citation for Model Regulation to Define Standards and Commissioner’s Authority for Companies Deemed
to be in Hazardous Financial Condition] then the Commissioner may require the insurer or the affiliated
person(s) to obtain and maintain a bond for the protection of the insurer for the duration of the contract(s)
or agreement(s).

The Commissioner’s review should consider, for example, whether concerns exist with respect to the
affiliated person’s ability to fulfill the contract or agreement if the insurer were to be put into
liquidation. Once the insurer is deemed to be in a hazardous financial condition and a bond is necessary, the Commissioner has discretion to determine the bond amount and whether a bond should be required for a single contract, multiple contracts, or contracts only with a specific person(s).

Again, AHIP and BCBSA appreciate this opportunity to offer comments on this issue, and we look forward to working with you to find the most productive way forward.

Sincerely,

Bob Ridgeway
Senior Government Relations Counsel
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Joe Zolecki
Director, Financial Regulatory Services
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312-297-5766
NOLHGA and NCIGF previously provided comments in response to the exposure of draft amendments to Models #440 and #450. During the Working Group's call on February 4, 2021, an interested party raised concerns about Section 5A(6) of Model #440, a section on which NOLHGA and NCIGF previously commented. As a proposed response to those concerns, NOLHGA and NCIGF offer the following edits to the text of Section 5A(6) and propose an accompanying drafting note.

Model #440 Section 5A(6)

(6) Supervision, seizure, conservatorship, or receivership proceedings.

(a) Any affiliate that is party to an agreement or contract with a domestic insurer pursuant to Subsection A(2)(d), shall be subject to the jurisdiction of any supervision, seizure, conservatorship, or receivership proceedings against the insurer, and to the authority of any supervisor, conservator, rehabilitator, or liquidator for the insurer appointed pursuant to [supervision and receivership acts] for the purpose of interpreting, enforcing, and overseeing the affiliate’s obligations under the agreement or contract to perform services for the insurer that agreements, relationship, and dealings with the insurer, if the services provided by the affiliate to the insurer:

(i) are an integral part of the insurer’s operations, including but not limited to management, administrative, accounting, data processing, marketing, underwriting, claims handling, investment, or any other similar functions; or

(ii) are essential to the insurer’s ability to fulfill its obligations under insurance policies.

(b) The Commissioner may require that an Any agreement or contract pursuant to Subsection A(2)(d) for the provision of services described in (i) and (ii) above must specify that the affiliate consents to the jurisdiction as set forth in this Section 5A(6).

DRAFTING NOTE: Section 5A(6) is not intended to subject affiliates, in particular those that may be subject to regulation in other jurisdictions, to the general jurisdiction of pending supervision, seizure, conservation or receivership court proceedings in this state, or the general authority of a supervisor, conservator or receiver for a domestic
insurer. Rather, the jurisdiction and authority conferred by this provision is limited to ensuring that a domestic insurer continues to receive essential services from an affiliate that it has contracted with to provide such services, in accordance with the terms of the contract and applicable law, during the aforementioned proceedings. Section 5A(6)(b) gives the Commissioner discretion to require documentation of an affiliate's consent to this jurisdiction in the agreement or contract. In determining appropriate circumstances when a Commissioner may require such provision, the Commissioner should consider the scope and materiality to the domestic insurer of the contract, the nature of the holding company system, and whether examination or investigation of the domestic insurer warrant requirement of such a provision.

****

We appreciate your consideration of these proposed changes, and we look forward to contributing to the Working Group's continued discussions.

Contact Information

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GUIDELINE FOR DEFINITION OF RECIPROCAL STATE IN RECEIVERSHIP LAWS

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

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

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

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

Definition of Reciprocal State for Receivership

“Reciprocal State” means a state that has enacted a law that sets forth a scheme for the administration of an insurer in receivership by the state’s insurance commissioner [or substitute the equivalent title used by the state, such as superintendent or director], or comparable insurance regulatory official.
REINSURANCE (E) TASK FORCE

Reinsurance (E) Task Force March 23, 2021, Minutes ...................................................................................................................... 10-963
Memorandum to the Financial Condition (E) Committee from the Group Capital Calculation (E) Working
Group Dated Feb. 25, 2021, Regarding Proposed New Charge for the Recognize and Accept Process
(Attachment One)........................................................................................................................................................................ 10-966
Draft Revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions (Attachment Two).................10-967
Maps Showing the Implementation of the 2019 Revisions to the Credit for Reinsurance Model Law (#785) and
the Credit for Reinsurance Model Regulation (#786); Status as of March 17, 2021 (Attachment Three) ...........10-996
The Reinsurance (E) Task Force met March 23, 2021. The following Task Force members participated: Chlora Lindley-Myers, Chair, represented by John Rehagen (MO); Raymond G. Farmer, Vice Chair (SC); Lori K. Wing-Heier represented by David Phifer (AK); Jim L. Ridling represented by Richard Ford (AL); Alan McClain represented by Mel Anderson (AR); Ricardo Lara represented by Monica Macaluso (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Kathy Belfi (CT); Trinidad Navarro represented by Dave Lonchar (DE); David Altmaier represented by Carolyn Morgan and Virginia Christy (FL); Doug Ommen (IA); Dana Popish Severinghaus represented by Eric Moser and Susan Berry (IL); Stephen W. Robertson represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Russell Coy and Vicki Lloyd (KY); James J. Donelon represented by Stewart Guerin (LA); Gary D. Anderson represented by Christopher Joyce (MA); Eric A. Cioppa represented by Robert Wake (ME); Troy Downing represented by Steve Matthews (MT); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Matt Fischer (ND); Bruce R. Ramge represented by Lindsay Crawford (NE); Chris Nicolopoulos represented by Doug Bartlett (NH); Marlene Caride represented by John Tirado (NJ); Russell Toal represented by Leatrice Geckler (NM); Linda A. Lacewell represented by Michael Campanelli (NY); Judith L. French represented by Dale Bruggeman (OH); Glen Mulready (OK); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Doug Slap represented by Jamie Walker (TX); Jonathan T. Pike represented by Jake Garn (UT); Scott A. White represented by David Smith and Doug Stolte (VA); and Michael S. Pieciak represented by David Provost (VT).

1. **Adopted its 2020 Fall National Meeting Minutes**

Mr. Eft made a motion, seconded by Ms. Geckler, to adopt the Task Force’s Nov. 17, 2020, minutes (see NAIC Proceedings – Fall 2020, Reinsurance (E) Task Force). The motion passed unanimously.


Mr. Kaumann provided the report of the Reinsurance Financial Analysis (E) Working Group. He stated that the Working Group met Jan. 28 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss the application of one new certified reinsurer. Mr. Kaumann stated that the Working Group would meet several more times during 2021 to complete the remaining reviews of certified reinsurers and to discuss any new applications. He noted that the Working Group intends to update the Reinsurance Financial Analysis (E) Working Group Procedures Manual (ReFAWG Manual) to include procedures for the review and approval of reciprocal jurisdiction reinsurers and to implement a passporting process similar to the process used for certified reinsurers.

Mr. Kaumann made a motion, seconded by Ms. Macaluso, to adopt the Working Group’s report. The motion passed unanimously.

3. **Adopted the Report of the Qualified Jurisdiction (E) Working Group**

Mr. Wake provided the report of the Qualified Jurisdiction (E) Working Group. He stated that the Working Group met March 17 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members) and paragraph 8 (considerations of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to: 1) discuss the initial review of a country being evaluated as a qualified jurisdiction; 2) provide updates on a previous initial review; and 3) conduct ongoing business.

Mr. Wake stated that in December 2020, the NAIC adopted revisions to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450), which adopted a group capital calculation (GCC) for the states. These revisions specifically include provisions that allow a commissioner to exempt groups that have a group-wide supervisor that recognize and accept the GCC for U.S. groups in their jurisdiction. Model #450 provides a general framework for how the recognition and acceptance process will work and specifically contemplates the development of a list of such jurisdictions.

Mr. Wake stated that the Financial Condition (E) Committee met March 8 and adopted a recommendation from the Group Capital Calculation (E) Working Group (Attachment One) to: 1) reposition the Qualified Jurisdiction (E) Working Group to
report directly to the Committee; 2) modify the 2021 charges to include developing a process for evaluating jurisdictions that meet the NAIC requirements for recognizing and accepting the NAIC GCC; and 3) revise the title of the group to be the Mutual Recognition of Jurisdictions (E) Working Group.

Mr. Wake noted that the Qualified Jurisdiction (E) Working Group was chosen to implement this charge because of the experience with reviewing qualified jurisdictions that recognize the U.S. state regulatory approach to group supervision and group capital for reciprocal jurisdiction purposes. He stated that issues related to the GCC will be communicated to the Committee while issues related to qualified and reciprocal jurisdictions will continue to be reported to the Task Force, in compliance with the Process for Evaluating Qualified and Reciprocal Jurisdictions.

Mr. Wake stated that the Working Group also discussed revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions (Attachment Two) during its March 17 meeting. He noted that the revisions would incorporate provisions for terminating the status of a qualified or reciprocal jurisdiction and would create a passporting process for reciprocal jurisdictions.

Karalee C. Morell (Reinsurance Association of America—RAA) requested that states that have adopted the 2019 revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) would communicate that there is a process in place to accept applications from reciprocal jurisdiction reinsurers. She noted that while both the certified reinsurer and reciprocal jurisdiction reinsurer programs are in place, there will be some administrative synergies. She asked if there had been consideration to using a streamlined process that relies on information gathered from certified reinsurer reviews that could be used for reciprocal jurisdiction reinsurers.

Mr. Wake noted that these concepts had been considered and would be discussed further when the ReFAWG Manual is updated. Mr. Kaumann agreed that this will be considered by the Reinsurance Financial Analysis (E) Working Group.

Dan Schelp (NAIC) stated that he had contacted the eight states that have adopted the 2019 revisions to Model #785 and Model #786 and noted that Iowa was only state that had received a formal application. He noted that for some states, the 2019 revisions are not effective yet. Mr. Schelp stated that he has been providing the state insurance regulators with the Uniform Checklist for Reciprocal Jurisdiction Reinsurers as a tool to assist in reviewing and approving reciprocal jurisdiction reinsurers.

Sabrina Miesowitz (Lloyd’s America) stated that she agrees with Ms. Morell’s comments and asked if additional guidance could be provided for how the process will work for current certified reinsurers that will become reciprocal jurisdiction reinsurers.

Mr. Schelp stated that additional guidance will be considered when the ReFAWG Manual is revised. He added that NAIC staff will work with state insurance regulators to ensure that the Task Force is aware of which states are ready to recognize reciprocal jurisdiction reinsurers and that the Mutual Recognition of Jurisdictions (E) Working Group could also address.

Mr. Wake made a motion, seconded by Mr. Bruggeman, to adopt the Working Group’s report and for the Task Force to expose the revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions for a 30-day comment period ending April 23. The motion passed unanimously.

4. Received a Status Report on the States’ Implementation of the 2019 Revisions to Model #785 and Model #786

Mr. Rehagen stated that as of March 18, 23 U.S. jurisdictions have adopted the 2019 revisions to Model #785, while 21 jurisdictions have action under consideration. He noted that eight states have adopted the revisions to Model #786, and six jurisdictions currently have action under consideration. He stated that the maps showing the adoption of the 2019 revisions to Model #785 and Model #786 were included in the meeting materials (Attachment Three).

Mr. Rehagen stated that the 2019 revisions to the models must be adopted by the states prior to Sept. 1, 2022, which is when the revisions become an accreditation standard. He noted that Sept. 1, 2022, is also the date at which the Federal Insurance Office (FIO) must complete its federal preemption reviews under the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement). He noted that the COVID-19 pandemic has slowed the adoption process, as several state legislatures have temporarily closed or have primarly focused on the pandemic. He stated that the Task Force will provide support to the states to meet this deadline, and it will communicate with the U.S. Department of the Treasury (Treasury Department) and the FIO as necessary. He noted that there have not been any specific conversations with either the FIO or the European Union (EU) about extending this deadline, but there have been some preliminary discussions with the FIO on the status of state adoptions.
Mr. Rehagen stated that the current adoption maps can be found on the Task Force’s web page. He noted that Mr. Schelp and Jake Stultz (NAIC) can answer any technical questions during the legislative process, and Holly Weatherford (NAIC) is working directly with the states on the adoption of the 2019 revisions to Model #785 and Model #786.

Having no further business, the Reinsurance (E) Task Force adjourned.
MEMORANDUM

To: Financial Condition (E) Committee

From: Group Capital Calculation (E) Working Group

Date: February 25, 2021

Re: Proposed New Charge for the Recognize and Accept Process

On Dec. 9, 2020, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC Insurance Holding Company System Model Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). These revisions will enable the Group Capital Calculation (GCC) once adopted by the states. The revisions specifically include provisions that allow the Commissioner to exempt groups that has a group-wide supervisor that “recognize and accept” the GCC for U.S. groups in their jurisdiction; thereby embracing the concepts of mutual recognition and one group/one group wide supervisor. Model #450 provides a general framework for how the “recognize and accept” process will work and specifically contemplates the development of “a list” of such jurisdictions. This concept of a list in the context of mutual recognition is not a new one and is already used by the Qualified Jurisdiction (E) Working Group of the Reinsurance (E) Task Force. To that end, the Working Group recommends the Financial Condition (E) Committee reposition the group to report directly to the Committee, modify the charges of the Qualified Jurisdiction (E) Working Group as shown below, and revise the title of the group to be more encompassing, as also shown in the following:

2021 Charges

The Qualified Mutual Recognition of Jurisdictions (E) Working Group will:

1. Develop a process for evaluating jurisdictions that meets the NAIC requirements for recognizing and accepting the NAIC Group Capital Calculation (GCC).
2. Maintain the NAIC List of Qualified Jurisdictions and the NAIC List of Reciprocal Jurisdictions in accordance with the Process for Evaluating Qualified and Reciprocal Jurisdictions.
3. Perform a yearly due diligence review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions.
4. Consider evaluations of any additional jurisdictions for inclusion on the NAIC List of Qualified Jurisdictions.

If you have any questions, please contact NAIC staff support Dan Daveline (ddaveline@naic.org).
Process for Evaluating Qualified and Reciprocal Jurisdictions
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   Appendix B: Regulatory Practices and Procedures
I. Preamble

Purpose

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

Background

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

The enactment in 2010 of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act), enacted in 2010. Further, the Dodd-Frank Act authorizes the U.S. Treasury Secretary and the U.S. Trade Representative (USTR), jointly, to negotiate and enter into “covered agreements” on behalf of the United States. These are bilateral or multilateral agreements with foreign governments, authorities or regulators relating to insurance prudential measures, which can preempt contrary state insurance laws or regulatory measures. The Dodd-Frank Act also created the Federal Insurance Office (FIO), which has the following authority: (1) coordinate federal efforts and develop federal policy on prudential aspects of international insurance matters; (2) assist the Secretary of the U.S. Department of the Treasury in negotiating covered agreements (as defined in the Dodd-Frank Act); (3) determine whether the states’ insurance measures are preempted by covered agreements; and (4) consult with the states (including state insurance regulators) regarding insurance matters of national importance and prudential insurance matters of international importance. Further, the Dodd-Frank Act authorizes the U.S. Treasury Secretary and the U.S. Trade Representative (USTR), jointly, to negotiate and enter into covered agreements on behalf of the United States. It is the NAIC’s intention to communicate and coordinate with the FIO and related federal authorities as appropriate with respect to the evaluation of the reinsurance supervisory systems of non-U.S. jurisdictions.
On September 22, 2017, the United States and the European Union (EU) entered into the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance.” A similar agreement with the United Kingdom (UK) was signed on December 18, 2018. Both agreements (collectively referred to as the “Covered Agreements”) will require the states to eliminate reinsurance collateral requirements for reinsurers licensed and domiciled in these jurisdictions within 60 months (five years) after signing or face potential federal preemption by the Federal Insurance Office (FIO) under the Dodd-Frank Act.

**Reciprocal Jurisdictions**

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

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

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

1. The NAIC model revisions applicable to certified reinsurers are intended to facilitate cross-border reinsurance transactions and enhance competition within the U.S. market, while ensuring that U.S. insurers and policyholders are adequately protected against the risk of insolvency. To be eligible for certification, a reinsurer must be domiciled and licensed in a Qualified Jurisdiction as determined by the domestic regulator of the ceding insurer. A Qualified Jurisdiction not subject to an in-force Covered Agreement under the Dodd-Frank Act may also be determined to be a Reciprocal Jurisdiction, and reinsurers that have their head office or are domiciled in any such Reciprocal Jurisdiction will not be required to post reinsurance collateral, provided they meet the minimum capital and financial strength requirements and comply with the other requirements of the Credit for Reinsurance Models.

2. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions and Reciprocal Jurisdictions will be conducted in accordance with the provisions of the Credit for Reinsurance Models and any other relevant guidance developed by the NAIC.

3. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions is intended as an outcomes-based comparison to financial solvency regulation under the NAIC Financial Regulation Standards and Accreditation Program (Accreditation Program), adherence to international supervisory standards, and relevant international guidance for recognition of reinsurance supervision. It is not intended as a prescriptive comparison to the NAIC Accreditation Program. In order for a Qualified Jurisdiction that is not subject to an in-force Covered Agreement to be evaluated as a Reciprocal Jurisdiction, that Qualified Jurisdiction must agree to recognize the states’ approach to group supervision, including group capital, and other such requirements as provided under the Credit for Reinsurance Models.

4. The states shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system within the Qualified Jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the U.S. The determination of Qualified Jurisdiction status is based on the effectiveness of the entire reinsurance supervisory system within the jurisdiction.

5. Each state may evaluate a non-U.S. jurisdiction to determine if it is a Qualified Jurisdiction. A list of Qualified Jurisdictions will be published through the NAIC committee process. A state must consider this list in its determination of Qualified Jurisdictions, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Qualified Jurisdictions contained in the Credit for Reinsurance Models. The creation of this list does not constitute a delegation of regulatory authority to the NAIC. The regulatory authority to recognize a Qualified Jurisdiction resides solely in each state and the NAIC List of Qualified Jurisdictions is not binding on the states.

6. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models.
7. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting,” as discussed more fully below in paragraph 15 of Section III, under which the commissioner has the discretion to defer to another state’s determination that a jurisdiction is a Qualified or Reciprocal Jurisdiction. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings. The NAIC Lists of Qualified and Reciprocal Jurisdictions are intended to facilitate the passporting process.

8. Both Qualified Jurisdictions and Reciprocal Jurisdictions must agree to share information and cooperate with the state with respect to all applicable reinsurers domiciled within that jurisdiction. Critical factors in the evaluation process include but are not limited to the history of performance by assuming insurers in the applicant jurisdiction and any documented evidence of substantial problems with the enforcement of final U.S. judgments in the applicant jurisdiction. A jurisdiction will not be a Qualified Jurisdiction if the commissioner has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.

9. The determination of Qualified Jurisdiction status can only be made with respect to the reinsurance supervisory system in existence and applied by a non-U.S. jurisdiction at the time of the evaluation.

10. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to the evaluation of the reinsurance supervisory systems of non-U.S. jurisdictions.
III. Procedure for Evaluation of Non-U.S. Jurisdictions

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

2. Evaluation of Jurisdiction
   a. Evaluation Materials. The Qualified Jurisdiction Working Group will initiate evaluation of a jurisdiction’s regulatory system by using the information identified in Section A through Section G of the Evaluation Methodology (Evaluation Materials). The Qualified Jurisdiction Working Group will begin by undertaking a review of the most recent Financial Sector Assessment Program (FSAP) Report prepared by the International Monetary Fund (IMF), including the Technical Note on Insurance Sector Supervision, and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system. The Qualified Jurisdiction Working Group will also invite each jurisdiction or its designee to provide information relative to Section A through Section G of the Evaluation Methodology in order to update, complete or supplement publicly available information. The Qualified Jurisdiction Working Group may also request or accept relevant information from reinsurers domiciled in the jurisdiction under review.
   b. The Qualified Jurisdiction Working Group will notify the jurisdiction of any information upon which the Working Group is relying. In that communication, the NAIC will invite the supervisory authority to compare the materials identified by the NAIC to the materials described in Appendix A and Appendix B, and provide information required to update the identified public information or supplement the public information, as required, to address the topics identified in Section A through Section G of the Evaluation Methodology. The use of publicly available information (e.g., the FSAP Report and/or the Insurance Sector Technical Note) is intended to lessen the burden on applicant jurisdictions by requiring the production of information that is readily available, while still addressing substantive areas of inquiry detailed in the Evaluation Methodology. The Qualified Jurisdiction Working Group’s review at this stage will be focused on how the jurisdiction’s laws, regulations, administrative practices and procedures, and regulatory authorities regulate the financial solvency of its domestic reinsurers in comparison to key principles.
underlying the U.S. financial solvency framework\(^1\) and other factors set forth in the Evaluation Methodology.

c. After reviewing the Evaluation Materials, the Qualified Jurisdiction Working Group may request that the applicant jurisdiction submit supplemental information as necessary to determine whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. The Working Group will address specific questions directly with the jurisdiction related to items detailed in the Evaluation Methodology that are not otherwise addressed in the Evaluation Materials.

d. The NAIC will request that all responses from the jurisdiction being evaluated be provided in English. Any responses submitted with respect to a jurisdiction’s laws and regulations should be provided by a person qualified in that jurisdiction to provide such analyses and, in the case of statutory analysis, qualified to provide such legal interpretations, to ensure that the jurisdiction is providing an accurate description.

e. The NAIC does not intend to review confidential company-specific information in this process, and has focused the procedure on reviewing publicly available information. No confidential company-specific information shall be disclosed or disseminated during the course of the jurisdiction’s evaluation unless specifically requested, subject to appropriate confidentiality safeguards addressed in a preliminary confidentiality and information-sharing agreement. If no such agreement is executed or the jurisdiction is unable to enter into such an agreement under its regulatory authority, the NAIC will not accept any confidential company-specific information.

3. NAIC Review of Evaluation Materials

a. NAIC staff and/or outside consultants with the appropriate knowledge, experience and expertise will review the jurisdiction’s Evaluation Materials.

b. Expenses with respect to the evaluations will be absorbed within the NAIC budget. This will be periodically reviewed.

c. Timeline for review. A project management approach will be developed with respect to the overall timeline applicable to each evaluation.

d. Upon completing its review of the Evaluation Materials, the internal reviewer(s) will report initial findings to the Qualified Jurisdiction Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation. Copies of the initial findings may also be made available to FIO and other relevant federal authorities subject to appropriate confidentiality and information-sharing agreements being in place.

4. Discretionary On-site Review

a. The NAIC may ask the jurisdiction under consideration for the opportunity to perform an on-site review of the jurisdiction’s reinsurance supervisory system. Factors that the Qualified Jurisdiction Working Group will consider in determining whether an on-site review is appropriate include the completeness of the information provided by the jurisdiction under review, the general familiarity of the jurisdiction by the NAIC staff or other state regulators participating in the review based on prior conduct or dealings with the jurisdiction.

\(^1\) The U.S. financial solvency framework is understood to refer to the key elements provided in the NAIC Financial Regulation Standards and Accreditation Program. Appendix A and Appendix B are derived from this framework.
jurisdiction, and the results of other evaluations performed by other regulatory or supervisory organizations. If the review is performed, it will be coordinated through the NAIC, utilizing personnel with the appropriate knowledge, experience and expertise. Individual states may also request that representatives from their state be added to the review team.

b. The review team will communicate with the supervisory authority in advance of the on-site visit to clearly identify the objectives, expectations and procedures with respect to the review, as well as any significant issues or concerns identified within the review of the Evaluation Materials. Information to be considered during the on-site review includes, but is not limited to, the following:

   i. Interviews with supervisory authority personnel.
   ii. Review of organizational and personnel practices.
   iii. Any additional information beneficial to gaining an understanding of document and communication flows.

c. Upon completing the on-site review, the reviewer(s) will report initial findings to the Qualified Jurisdiction Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation.

5. Standard of Review

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

6. Additional Information to be Considered as Part of Evaluation

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

a. Documents, reports and information from appropriate international, U.S. federal and U.S. state authorities.

b. Public comments from interested parties.

c. Rating agency information.

d. Any other relevant information.

7. Preliminary Evaluation Report

a. NAIC staff and/or outside consultants will prepare a Preliminary Evaluation Report for review by the Qualified Jurisdiction Working Group. This preliminary report will be private and confidential (i.e., may only be reviewed by Working Group members, designated NAIC staff, consultants, the states, the FIO and
other relevant federal authorities that specifically request to be kept apprised of this information, provided that such entities have entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction. Any outside consultants retained by the NAIC will be required to enter into a confidentiality and nondisclosure agreement.

b. The report will be prepared in a consistent style and format to be developed by NAIC staff. It will contain detailed advisory information and recommendations with respect to the evaluation of the jurisdiction’s reinsurance supervisory system and the documented practices and procedures thereunder. The report will contain a recommendation as to whether the NAIC should recognize the jurisdiction as a Qualified Jurisdiction.

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


a. The Qualified Jurisdiction Working Group’s review of the Preliminary Evaluation Report will be held in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings.

b. The Qualified Jurisdiction Working Group will make a preliminary determination as to whether the jurisdiction under consideration satisfies the Standard of Review and is deemed acceptable to be included on the NAIC List of Qualified Jurisdictions. If the preliminary determination is that the jurisdiction should not be included on the NAIC List of Qualified Jurisdictions, the Qualified Jurisdiction Working Group will set forth its specific findings and identify those areas of concern with respect to this determination.

c. The results of the Preliminary Evaluation Report will be immediately communicated in written form to the supervisory authority of the jurisdiction under review.


a. Upon receipt of the Preliminary Evaluation Report, the supervisory authority will have an opportunity to respond to the initial findings and determination. This is not intended to be a formal appeals process that would initiate U.S. state administrative due process requirements.

b. The Qualified Jurisdiction Working Group will consider any response, and will proceed to prepare its Final Evaluation Report. The Qualified Jurisdiction Working Group will consider the Final Evaluation Report for approval in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings. This report will be approved upon an affirmative vote of a majority of the members in attendance at this meeting.

c. Upon approval of the Final Evaluation Report, the Qualified Jurisdiction Working Group will issue a public statement and a summary of its findings with respect to its determination. At this time, the Working Group will release the summary for public comment. The detailed report will be a confidential, regulator-only document. The report may be shared with any state indicating that it is considering relying on the NAIC List of Qualified Jurisdictions and has entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction.
10. NAIC Determination Regarding List of Qualified Jurisdictions

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

b. In the event that a jurisdiction is not approved as a Qualified Jurisdiction, the supervisory authority will be eligible for reapplication at the discretion of the NAIC.

c. Upon final adoption of the Qualified Jurisdiction Working Group’s determination with respect to a jurisdiction, the Final Evaluation Report will be made available to individual U.S. state insurance regulators upon request and confirmation that the information contained therein will remain confidential.

11. Memorandum of Understanding (MOU)

a. A Qualified Jurisdiction must agree to share information and cooperate on a confidential basis with the U.S. state insurance regulatory authority with respect to all certified reinsurers domiciled within that jurisdiction.

b. The International Association of Insurance Supervisors (IAIS) Multilateral Memorandum of Understanding (MMoU) is the recommended method under which a Qualified Jurisdiction will agree to share information and cooperate with U.S. state insurance regulatory authorities. However, until such time as a state has been approved as a signatory to the MMoU by the IAIS, the state may rely on an MOU entered into by a “Lead State” designated by the NAIC. This Lead State will act as a conduit for information between the Qualified Jurisdiction and other states that have certified a reinsurer domiciled and licensed in that jurisdiction, and will share information with these states consistent with the terms governing the further sharing of information included in the NAIC Master Information Sharing and Confidentiality Agreement, and, as applicable, in the applicable IAIS MMoU, or or in a bilateral MOU between the Lead State and the Qualified Jurisdiction and pursuant to the NAIC Master Information Sharing and Confidentiality Agreement. The jurisdiction must also confirm in writing that it is willing to permit this Lead State to act as the contact for purposes of obtaining information concerning its certified reinsurers, provided the that Lead State share that information with the other states requesting the information only in a manner consistent with the terms governing the further sharing of information included, as in the applicable, in the IAIS MMoU or bilateral MOU between the Lead State and the Qualified Jurisdiction.

c. If a Qualified Jurisdiction has not been approved by the IAIS for use as a party to the MMoU, it must enter into an MOU with a Lead State. The MOU must provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions.

d. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to this process.
12. Process for Evaluation after Initial Approval

   a. The process for determining whether a non-U.S. jurisdiction is a Qualified Jurisdiction is ongoing and subject to periodic review. The Qualified Jurisdiction Working Group will perform a yearly review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions. This yearly review shall follow such abbreviated process as may be determined by the Qualified Jurisdiction Working Group to be appropriate.

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

   c. If the Qualified Jurisdiction Working Group finds the jurisdiction to be out of compliance at any time with the requirements to be a Qualified Jurisdiction, the specific reasons will be documented in a report to the jurisdiction under review, and the status as a Qualified Jurisdiction may be placed on probation, suspended or revoked.

   d. The Qualified Jurisdiction Working Group will monitor those jurisdictions that have been approved as Qualified Jurisdictions by individual states, but are not included on the NAIC List of Qualified Jurisdictions.

13. Review of Qualified Jurisdictions as Potential Reciprocal Jurisdictions

   a. In undertaking the evaluation of whether to designate a Qualified Jurisdiction as a Reciprocal Jurisdiction, the Qualified Jurisdiction Working Group shall utilize such processes and procedures as outlined in the immediately-preceding paragraphs 1 – 12 of Section III. Procedure for Evaluation of Non-U.S. Jurisdictions such as the Qualified Jurisdiction Working Group deems is appropriate. Specifically, the Qualified Jurisdiction Working Group will use processes and procedures outlined in paragraph 1 (Initiation of Evaluation of the Reinsurance Supervisory System of an Individual Jurisdiction), paragraph 3 (NAIC Review of Evaluation Materials), paragraph 7 (Preliminary Evaluation Report), paragraph 8 (Review of Preliminary Evaluation Report), paragraph 9 (Opportunity to Respond to Preliminary Evaluation Report), paragraph 10 (NAIC Determination regarding List of Qualified Jurisdictions), paragraph 11 (Memorandum of Understanding) and paragraph 12 (Process for Evaluation after Initial Approval), as modified for use with applicants for Reciprocal Jurisdiction status.

   b. A Qualified Jurisdiction may not be reviewed for inclusion on the NAIC List of Reciprocal Jurisdictions unless it has undergone the Evaluation Methodology outlined in Section IV, and remains in good standing with the NAIC as a Qualified Jurisdiction. The Qualified Jurisdiction Working Group may, if it determines
an extended review period to be appropriate after its initial approval of a new Qualified Jurisdiction, defer consideration of that jurisdiction as a possible Reciprocal Jurisdiction until there has been sufficient United States experience with that jurisdiction and its Certified Reinsurers that the Working Group believes it is appropriate to progress from collateral reduction to collateral elimination. Nothing in this process requires a finding that a Qualified Jurisdiction meets the standards for recognition as a Reciprocal Jurisdiction, and the Qualified Jurisdiction Working Group may base such recommendation on all relevant information, which may include factors not specifically included in this Process for Evaluating Qualified and Reciprocal Jurisdictions.

c. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the NAIC List of Reciprocal Jurisdictions. In making its recommendation with respect to whether a Qualified Jurisdiction that is not automatically designated as a Reciprocal Jurisdiction should be added to the NAIC List of Reciprocal Jurisdictions, the Qualified Jurisdiction Working Group shall undertake the following analysis in making its evaluation:

i. The Qualified Jurisdiction must confirm that an insurer which has its head office or is domiciled in that jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as the same insurer would receive credit for reinsurance assumed by an assuming insurers domiciled in that jurisdiction is received by United States ceding insurers;

ii. The Qualified Jurisdiction must confirm that it does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by that jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

iii. The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurance groups that are domiciled or maintain their worldwide headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision, including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision by the Qualified Jurisdiction at the level of the worldwide parent undertaking of the insurance or reinsurance group by the Qualified Jurisdiction;

iv. The Qualified Jurisdiction must provide written confirmation by its competent regulatory authority that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the Qualified Jurisdiction, including but not limited to the IAIS MMoU or other multilateral memoranda of understanding coordinated by the NAIC This requirement may be satisfied by an MOU with a Lead State, which shall provide for appropriate confidentiality safeguards with respect to the information...
shared between the jurisdictions, similar to the MOU requirement outlined in paragraph 11 of this section III; and

v. The Qualified Jurisdiction must confirm that it will provide to the states on an annual basis confirmation that each eligible assuming insurer that is domiciled in the Qualified Jurisdiction continues to comply with the requirements set forth in in Section 9C(2) and (3) of Model #786; i.e., must maintain, on an ongoing basis, minimum capital and surplus of no less than $250,000,000, and maintains on an ongoing basis the required minimum solvency or capital ratio, as applicable.

d. In order to satisfy the requirements of subsection (c) above, the chief insurance supervisor of the Qualified Jurisdiction being evaluated as a Reciprocal Jurisdiction may provide the NAIC with a written letter confirming, as follows:

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

• An insurer which has its head office or is domiciled in [Jurisdiction] shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit would be granted for reinsurance assumed by insurers domiciled in [Jurisdiction] is received by United States ceding insurers. [Jurisdiction] does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by [Jurisdiction] or as a condition to allow the ceding insurer to recognize credit for such reinsurance.

• [Jurisdiction] recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that insurance groups that are domiciled or maintain their worldwide headquarters in jurisdictions accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the [Jurisdiction].

• [Jurisdiction] confirms that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the [Jurisdiction].

• [Jurisdiction] will annually provide to the states confirmation that applicable assuming insurers domiciled in [Jurisdiction] maintain minimum capital and surplus of no less than $250,000,000, and maintain on an ongoing basis the required minimum solvency or capital ratio, as applicable.
Finally, I confirm that [Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

e. The Qualified Jurisdiction Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination, the representations in the letter are true and accurate, and will prepare for the review by the Reinsurance Task Force a Summary of Findings and Determination recommending that the Qualified Jurisdiction be recognized as a Reciprocal Jurisdiction. Upon approval by the Task Force, the Summary of Findings and Determination must be adopted by will be submitted for a vote of the NAIC Executive (EX) Committee and Plenary for inclusion on the List of Reciprocal Jurisdictions.

f. The Qualified Jurisdiction Working Group, working in coordination with the Qualified Jurisdiction and the Reinsurance Financial Analysis (E) Working Group, must make a determination on a minimum solvency or capital ratio under which reinsurers licensed and domiciled in the Qualified Jurisdiction may assume insurance from U.S. ceding companies without posting reinsurance collateral. The applicable minimum solvency or capital ratio must be an effective measure of solvency, comparable to either an NAIC risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, or one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union, giving due consideration to any applicable equivalency assessment conducted by the European Insurance and Occupational Pensions Authority (EIOPA) on the Qualified Jurisdiction with respect to Solvency II.

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

a. If the Qualified Jurisdiction Working Group finds a Qualified Jurisdiction to be out of compliance at any time with the requirements to be a Qualified Jurisdiction, the specific reasons will be documented in a report to the jurisdiction under review. The Qualified Jurisdiction Working Group would then report any concerns to its parent Task Force for further discussion and communication with appropriate federal and/or international authorities, and the status as a Qualified Jurisdiction may be placed on probation, suspended or revoked by the NAIC.

b. Except for Reciprocal Jurisdictions entitled to automatic recognition, a jurisdiction’s status as a Reciprocal Jurisdiction may be placed on probation, suspended or revoked for good cause in the same manner as provided for Qualified Jurisdictions under paragraph 12. If cause is found to question the fitness of a Reciprocal Jurisdiction that is subject to an in-force Covered Agreement, or its compliance with applicable requirements of the covered agreement, the Qualified Jurisdiction Working Group would report any concerns to its parent Task Force for further discussion and communication with appropriate federal and/or international authorities. It is intended that compliance with the covered agreement will ultimately be determined by the Joint Committee established under the covered agreement, or through termination of the covered agreement by the parties to the covered agreement.

c. Both Qualified Jurisdictions and Reciprocal Jurisdictions that are not subject to a covered agreement are obligated to provide notice to the Qualified Jurisdiction Working Group of any applicable changes to their
reinsurance supervisory system or changes to the assurances provided in the letter set forth in paragraph 13. States and U.S. ceding insurers may also provide notice of such changes to the Working Group. Upon notice of any such material changes, the Working Group will meet in regulator-only session to determine if these changes are in fact material to continuing recognition by the NAIC as either a Qualified or Reciprocal Jurisdiction. The Working Group will work directly with the jurisdiction to address any issues that have been identified. If these issues cannot be resolved through this regulator-only dialogue, then the Working Group will report its recommendation to the Reinsurance Task Force, which will consider a suspension of the jurisdiction’s status as a Qualified or Reciprocal Jurisdiction in open session. The Task Force will then make a recommendation to the NAIC Plenary on the action, if any, to be taken, which may include placing the Qualified or Reciprocal Jurisdiction’s status on probation, or suspending or revoking its status.

d. If a Qualified or Reciprocal Jurisdiction’s status is placed on probation by the NAIC, the material change will be noted in an update to its Summary of Finding and Determination in order to provide notice to the states and U.S. ceding insurers of this material change. If the NAIC decides to suspend or revoke its status, the jurisdiction may be given a reasonable time period, no more than 18 months, to rectify its noncompliance with the standards and return it to good standing. Once the NAIC’s suspension or revocation takes effect, it is expected that the same action will be taken by the respective states that have recognized the jurisdiction as a Qualified or Reciprocal Jurisdiction.

e. There is no administrative right to appeal the decision of the NAIC with respect to the revocation of status as a Qualified or Reciprocal Jurisdiction, but the jurisdiction can apply for reinstatement after a one-year period.

b.f. During the period in which a Qualified or Reciprocal Jurisdiction’s status has been suspended by a state, any new reinsurance assumed by a reinsurer domiciled in that jurisdiction from a ceding insurer domiciled in that state will not be eligible for credit unless the transaction qualifies for credit on the basis of security posted by the ceding insurer or some other basis that does not depend on recognition of the jurisdiction as a Qualified or Reciprocal Jurisdiction. However, suspension does not affect credit for reinsurance that was already in force.

g. If a Qualified or Reciprocal Jurisdiction’s status is revoked by a state, then those Certified Reinsurers and/or Reciprocal Jurisdiction Reinsurers domiciled in that jurisdiction must post within three months of this determination one hundred percent (100%) collateral on all their liabilities assumed from ceding insurers domiciled in that state.

h. The factors used in the evaluation of Reciprocal Jurisdictions are not the same as are utilized in the evaluation of Qualified Jurisdictions. A Qualified Jurisdiction that has been approved by the NAIC as a Reciprocal Jurisdiction may have its status as a Reciprocal Jurisdiction either suspended or revoked but still meet the requirements to be a Qualified Jurisdiction. However, if a Reciprocal Jurisdiction that is not subject to a covered agreement has its status as a Qualified Jurisdiction revoked, it cannot maintain its status as a Reciprocal Jurisdiction, because it must be a Qualified Jurisdiction to meet the requirements of a Reciprocal Jurisdiction.
15. Passorting Process for Reciprocal Jurisdictions

a. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passorting” under which the commissioner has the discretion to defer to another state’s determination with respect to the requirements for both Certified Reinsurers and Reciprocal Jurisdiction Reinsurers. Passorting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passorting process. States are also encouraged to utilize the passorting process to reduce the amount of documentation filed with the states and reduce duplicate filings.

b. The passorting process is facilitated through the Reinsurance Financial Analysis (E) Working Group (ReFAWG). It is intended that ReFAWG will help facilitate multi-state recognition of Certified Reinsurers and Reciprocal Jurisdiction Reinsurers and address issues of uniformity among the states, both with respect to initial application and subsequent changes in rating or status. The ReFAWG Review Process is set forth in the ReFAWG Procedures Manual.

c. Section 9C(7) of the Credit for Reinsurance Model Regulation (#786) provides that the “assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with the requirements set forth in Paragraphs (2) [i.e., minimum capital and surplus of no less than $250] and (3) [i.e., minimum solvency or capital ratio] of this subsection.” Section 9E(1) of Model #786 then provides that “The commissioner may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC in satisfaction of the requirements of Subsection C.” A Reciprocal Jurisdiction may satisfy the requirements of Section 9C(7) of Model #786 by annually filing the required information with each state in which it is doing business, or with either its Lead State or the NAIC, which will share this documentation with the other states through the ReFAWG Review Process. Each state may accept financial documentation filed with the Lead State or with the NAIC.
IV. Evaluation Methodology

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

The Evaluation Methodology consists of the following:

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

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

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

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

1. Confirmation of the jurisdiction’s most recent FSAP Report, including relevant updates with respect to descriptions or elements of the FSAP Report in which changes have occurred since the assessment or where information might otherwise be outdated.

2. Confirmation of the jurisdiction’s ROSC, including relevant updates with respect to descriptions or elements of the ROSC in which changes have occurred since the report was completed or where information might otherwise be outdated.

3. If materials responsive to the topics under review have been provided in response to information exchanges between the jurisdiction under review and the NAIC, such prior responses may be cross-referenced provided updates are submitted, if required to address changes in laws or procedures.

4. Any other information, descriptions or responses the jurisdiction believes would be beneficial to the NAIC’s evaluation process in order to address, on an outcomes basis, the key elements described within Appendix A.

The NAIC will review the information provided by the applicant jurisdiction and determine whether it is adequate to reasonably conclude whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. After reviewing the initial submission, the NAIC may request that the applicant jurisdiction

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2 The basic considerations under this section are derived from Model #786, Section 8C(2), which include: (a) the framework under which the assuming reinsurer is regulated; (b) the structure and authority of the jurisdiction’s reinsurance supervisory authority with regard to solvency regulation requirements and financial surveillance; (c) the substance of financial and operating standards for reinsurers domiciled in the jurisdiction; and (d) the form and substance of financial reports required to be filed or made publicly available by reinsurers domiciled in the jurisdiction and the accounting principles used.
submit supplemental information as necessary in order to make this determination. An applicant jurisdiction is strongly encouraged to provide thorough, detailed and current information in its initial submission in order to minimize the number and extent of supplemental information requests from the NAIC with respect to Section A of this Evaluation Methodology. The NAIC will provide a complete description in the Final Evaluation Report of the information provided in the Evaluation Materials, and any updates or other information that have been provided by the applicant jurisdiction.

Section B: Regulatory Practices and Procedures

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

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

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

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

Section D: Regulatory Cooperation and Information-Sharing

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

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

a. Number of reinsurers domiciled in the jurisdiction, and a list of any reinsurers domiciled in the jurisdiction that have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, of no less than $250,000,000.

b. Up to a 10-year history of any regulatory actions taken against specific reinsurers.

c. Up to a 10-year history listing any reinsurers that have gone through insolvency proceedings, including the size of each insolvency and a description of the related outcomes (e.g., reinsurer rehabilitated or liquidated, payout percentage of claims to priority classes, payout percentage of claims to domestic and foreign claimants).

d. Up to a 10-year history of any significant industry-wide fluctuations in capital or profitability with respect to domestic reinsurers.

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

Section F: Enforcement of Final U.S. Judgments

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

Section G: Solvent Schemes of Arrangement

The jurisdiction is requested to provide a description of any legal framework that allows reinsurers domiciled in the jurisdiction to propose or participate in any solvent scheme of arrangement or similar procedure. In addition, the jurisdiction is requested to provide a description of any solvent scheme of arrangement or similar procedure that a domestic reinsurer has proposed or participated in and the outcome of such procedure.
V. Appendices: Specific Guidance with Respect to Section A and Section B

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

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

1. Examination Authority

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

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

2. Capital and Surplus Requirement

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

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

3. Accounting Practices and Procedures

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

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

4. Corrective Action

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

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

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

a. Whether the jurisdiction has the authority to require a diversified investment portfolio for all domestic reinsurers as to type, issue and liquidity.

b. Whether the jurisdiction has the authority to establish acceptable practices and procedures under which investments owned by reinsurers must be valued, including standards under which reinsurers are required to value securities/investments.

6. **Holding Company Systems**

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

a. Whether the jurisdiction has access to information via the parent or other regulated group entities about activities or transactions within the group involving other regulated or non-regulated entities that could have a material impact on the operations of the reinsurer.

b. Whether the jurisdiction has access to consolidated financial information of a reinsurer’s ultimate controlling person.

c. Whether the jurisdiction has the authority to review integrity and competency of management.

b. Whether the jurisdiction has approval and intervention powers for material transactions and events involving reinsurers.

e. Whether the jurisdiction has authority to monitor, or has prior approval authority over:
   i. Change in control of domestic reinsurers.
   ii. Dividends and other distributions to shareholders of the reinsurer.
   iii. Material transactions with affiliates.

7. **Risk Management**

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

a. Whether the jurisdiction has Own Risk and Solvency Assessment (ORSA) requirements and reporting.

b. Any requirements regarding the maximum net amount of risk to be retained by a reinsurer for an individual risk based on the reinsurer’s capital and surplus.

c. Whether the jurisdiction has authority to monitor enterprise risk, including any activity, circumstance, event (or series of events) involving one or more affiliates of a reinsurer that, if not remedied promptly, is likely to have a material adverse effect on the financial condition or liquidity of the reinsurer or its insurance holding company system as a whole.

d. Whether the jurisdiction has corporate governance requirements for reinsurers.
8. **Liabilities and Reserves**

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

a. Liabilities incurred under reinsurance contracts for policy reserves, unearned premium, claims and losses unpaid, and incurred but not reported (IBNR) claims (including whether discounting is allowed for reserve calculation/reporting).

b. Liabilities related to catastrophic occurrences.

c. Whether the jurisdiction requires an opinion on reserves and loss and loss adjustment expense reserves by a qualified actuary or specialist for all domestic reinsurers, and the frequency of such reports.

9. **Reinsurance Ceded**

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

a. Credit for reinsurance requirements applicable to reinsurance retroceded to domestic and non-domestic reinsurers.

b. Collateral requirements applicable to reinsurance contracts.

c. Whether the jurisdiction requires a reinsurance agreement to provide for insurance risk transfer (i.e., transfer of both underwriting and timing risk).

d. Requirements applicable to special purpose reinsurance vehicles and insurance securitizations.

e. Affiliated reinsurance transactions and concentration risk.

f. Disclosure requirements specific to reinsurance transactions, agreements and counterparties, if such information is not provided under another item.

10. **Independent Audits**

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

a. Requirements for the filing of audited financial statements prepared in conformity with accounting practices prescribed or permitted by the supervisory authority.

b. Contents of annual audited financial reports.

c. Requirements for selection of auditor.

d. Allowance of audited consolidated or combined financial statements.

e. Notification of material misstatements of financial condition.

f. Supervisor’s access to auditor’s workpapers.

g. Audit committee requirements.

h. Requirements for reporting of internal control-related matters.

11. **Receivership**

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

12. Filings with Supervisory Authority

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

a. The use of standardized financial reporting in the financial statements, and the frequency of relevant updates.

b. The use of supplemental data to address concerns with specific companies or issues.

c. Filing format (e.g., electronic data capture).

d. The extent to which financial reports and information are public records.

13. Reinsurance Intermediaries

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

14. Other Regulatory Requirements with respect to Reinsurers

Any other information necessary to adequately describe the effectiveness of the jurisdiction’s laws and regulations with respect to its reinsurance supervisory system.
Appendix B: Regulatory Practices and Procedures

1. Financial Analysis

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

a. Qualified Staff and Resources
   The resources employed to effectively review the financial condition of all domestic reinsurers, including a description of the educational and experience requirements for staff responsible for financial analysis.

b. Communication of Relevant Information to/from Financial Analysis Staff
   The process under which relevant information and data received by the supervisory authority are provided to the financial analysis staff and the process under which the findings of the financial analysis staff are communicated to the appropriate person(s).

c. Supervisory Review
   How the jurisdiction’s internal financial analysis process provides for supervisory review and comment.

d. Priority-Based Analysis
   How the jurisdiction’s financial analysis procedures are prioritized in order to ensure that potential problem reinsurers are reviewed promptly.

e. Depth of Review
   How the jurisdiction’s financial analysis procedures ensure that domestic reinsurers receive an appropriate level or depth of review commensurate with their financial strength and position.

f. Analysis Procedures
   How the jurisdiction has documented its financial analysis procedures and/or guidelines to provide for consistency and continuity in the process and to ensure that appropriate analysis procedures are being performed on each domestic reinsurer.

g. Reporting of Material Adverse Findings
   The process for reporting material adverse indications, including the determination and implementation of appropriate regulatory action.

h. Early Warning System/Stress Testing
   Whether the jurisdiction has an early warning system and/or stress testing methodology that is utilized with respect to its domestic reinsurers.
2. Financial Examinations

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

a. **Qualified Staff and Resources**
   The resources employed to effectively examine all domestic reinsurers. This should include whether the jurisdiction prioritizes examination scheduling and resource allocation commensurate with the financial strength and position of each reinsurer, and a description of the educational and experience requirements for staff responsible for financial examinations.

b. **Communication of Relevant Information to/from Examination Staff**
   The process under which relevant information and data received by the supervisory authority are provided to the examination staff and the process under which the findings of the examination staff are communicated to the appropriate person(s).

c. **Use of Specialists**
   Whether the supervisory authority’s examination staff includes specialists with appropriate training and/or experience or whether the supervisory authority otherwise has available qualified specialists that will permit the supervisory authority to effectively examine any reinsurer.

d. **Supervisory Review**
   Whether the supervisory authority’s procedures for examinations provide for supervisory review.

e. **Examination Guidelines and Procedures**
   Description of the policies and procedures the supervisory authority employs for the conduct of examinations, including whether variations in methods and scope are commensurate with the financial strength and position of the reinsurer.

f. **Risk-Focused Examinations**
   Does the supervisory authority perform and document risk-focused examinations and, if so, what guidance is utilized in conducting the examinations? Are variations in method and scope commensurate with the financial strength and position of the reinsurer?

g. **Scheduling of Examinations**
   Whether the supervisory authority’s procedures provide for the periodic examination of all domestic reinsurers, including how the system prioritizes reinsurers that exhibit adverse financial trends or otherwise demonstrate a need for examination.

h. **Examination Reports**
   Description of the format in which the supervisory authority’s reports of examinations are prepared, and how the reports are shared with other jurisdictions under information-sharing agreements.

i. **Action on Material Adverse Findings**
   What are the jurisdiction’s procedures regarding supervisory action in response to the reporting of any material adverse findings.
3. **Information Sharing**

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

4. **Procedures for Troubled Reinsurers**

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

5. **Organization, Licensing and Change of Control of Reinsurers**

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

a. **Licensing Procedure**
   Whether the supervisory authority has documented licensing procedures that include a review and/or analysis of key pieces of information included in a primary licensure application.

b. **Staff and Resources**
   The educational and experience requirements for staff responsible for evaluating company licensing.

c. **Change in Control of a Domestic Reinsurer**
   Procedures for the review of key pieces of information included in filings with respect to a change in control of a domestic reinsurer.
Implementation of the 2019 Revisions to the Credit for Reinsurance Model Law #785
[status as of March 18, 2021]

Disclaimer: This map represents state action or pending state action regarding NAIC amendments to the model(s). This map does not reflect a determination as to whether the pending or enacted legislation contains all elements of NAIC amendments to the model(s) or whether a state meets any applicable accreditation standards.
Implementation of the 2019 Revisions to the Credit for Reinsurance Model Regulation #786
[status as of March 18, 2021]

Disclaimer: This map represents state action or pending state action regarding NAIC amendments to the model(s). This map does not reflect a determination as to whether the pending or enacted legislation contains all elements of NAIC amendments to the model(s) or whether a state meets any applicable accreditation standards.
RISK RETENTION GROUP (E) TASK FORCE

Risk Retention Group (E) Task Force Feb. 24, 2021, Minutes.................................................................10-999
Risk Retention Group (E) Task Force Feb. 5, 2021, Minutes (Attachment One).................................10-1001
Survey for Non-Domiciliary and Domiciliary Risk Retention Group (RRG) Regulators
(Attachment One-A)..............................................................................................................................10-1002
The Risk Retention Group (E) Task Force met Feb. 24, 2021. The following Task Force members participated: Michael S. Pieciak, Chair, represented by Sandra Bigglestone (VT); Karima M. Woods, Vice Chair, represented by Sean O’Donnell (DC); Sharon P. Clark represented by Jeff Gaither (KY); Troy Downing represented by Steve Matthews (MT); and Raymond G. Farmer represented by Daniel Morris (SC).

1. **Adopted its Feb. 5, 2021, and 2020 Fall National Meeting Minutes**

The Task Force conducted an e-vote that concluded Feb. 5, 2021, to approve the distribution of a survey to state insurance regulators with the purpose to provide the Task Force with insight into future improvements and priorities in the areas of risk retention group (RRG) regulation, registration and training.

Mr. O’Donnell made a motion, seconded by Mr. Matthews, to adopt the Task Force’s Feb. 5, 2021 (Attachment One) and Nov. 18, 2020 (see NAIC Proceedings – Fall 2020, Risk Retention Group (E) Task Force) minutes. The motion passed unanimously.

2. **Discussed the Applicability of Revisions to Model #440 and Model #450 Related to the GCC as an Accreditation Standard for RRGs**

Ms. Bigglestone stated that in 2020, the NAIC adopted revisions to the *Insurance Holding Company Systems Regulatory Act* (#440) and the *Insurance Holding Company Systems Model Regulation* (#450). The changes relate to applying a group capital calculation (GCC) to groups with at least one insurer and one affiliate. She also stated there were revisions related to liquidity stress testing. However, she said these sections only apply to life insurers and, therefore, are not applicable to RRGs, which can only write property/casualty (P/C) business.

Ms. Bigglestone noted that the Task Force typically considers applicability of accreditation standards to RRGs after a recommended change to the standards is referred to the Financial Regulation Standards and Accreditation (F) Committee and the recommendation is exposed. At the time of this meeting, the referral still resides with the Group Capital Calculation (E) Working Group. However, the current referral suggests accelerating the timeline for adoption of the revisions and an accelerated effective date for accreditation. Therefore, today’s Task Force discussion will not result in a decision, but rather will help provide a foundation for future considerations on applicability to RRGs in the event adoption of the revised accreditation standard moves quickly.

Dan Daveline (NAIC) said that the initial instructions given to the Group Capital Calculation (E) Working Group, tasked with the development of a GCC, were to develop an aggregation method for group capital that builds on risk-based-capital (RBC). The aggregation method developed is essentially a miniature consolidation using eliminations to avoid double counting. With this methodology, the calculation is only as complex as the group itself, and even if there are a lot of affiliates, there are options to combine multiple entities into a single line of reporting. The GCC is intended to be a valuable tool for group oversight that will be incorporated into the Group Profile Summary (GPS). The combination of value and simplicity allows broad application, and the intention is that the GCC applies to all insurance holding company groups. Mr. Daveline noted, however, that it is not uncommon for RRGs to file a disclaimer of affiliation and in those instances when an insurer is not part of a group subject to other holding company filings, the GCC filing would also not apply. The only complete exemption from the GCC (or similar federal or international capital standard) set forth in Model #440 is for groups with only one insurer, which writes only in the state of domicile. There was some discussion about exempting groups under a certain dollar threshold, but the decision was made to subject all groups to the GCC, with the option to seek a waiver after the first year.

Mr. Daveline stated that the GCC has strong confidentiality provisions. The filing is to go to the lead state and only the lead state. In regard to public availability of the GCC, the revisions to Model #440 prevent the insurer from making the calculation public in any way. The calculation is intended as a regulatory tool, not a standard for public comparison of groups.

Becky Meyer (NAIC) provided a summary of the typical adoption process for a new or revised Part A: Laws and Regulations accreditation standard as outlined in the *Accreditation Program Manual*. If adopted through the normal timeline, the effective date for accreditation would be Jan. 1, 2026. However, the referral suggests obtaining a waiver and implementing an effective
date as early as Nov. 7, 2022. Ms. Meyer stated that one potential outcome of the waiver and related bifurcation of effective dates suggested in the referral is expedited adoption of the standard, but an effective date that provides adequate time for adoption by all states. The Financial Regulation Standards and Accreditation (F) Committee is expected to receive a referral from the Group Capital Calculation (E) Working Group at the Spring National Meeting and begin discussion of the topic upon receipt.

Ms. Bigglestone stated that the Task Force expects to consider the issue further when the standard is exposed by the Financial Regulation Standards and Accreditation (F) Committee. States are encouraged to begin considering the potential implications on their domestic RRGs, including any concerns in applying the GCC, as well as potential benefits of obtaining the GCC for ongoing analysis.

3. **Discussed the Financial Analysis Non-Troubled Insurer Procedures**

Ms. Bigglestone stated that revisions to the NAIC *Financial Analysis Handbook* (Handbook) were adopted in 2020 to better incorporate RRG-specific procedures within the risk assessment worksheet and to remove outdated guidance that RBC is not applicable for RRGs. Following these changes, further review of the Handbook identified the Quarterly Quantitative Assessment of Non-Troubled Insurers as another area to consider updates related to RRGs. These procedures generate a set of indicators for any company not considered troubled by the domestic regulator. The results of these indicators help the analyst determine the depth of procedures necessary to perform in the first, second and third quarters. Two indicators, prior year RBC less than 250% and prior year triggered the RBC Trend Test, exclude RRGs from use of these indicators. However, since RBC is calculated for RRGs, this exclusion is likely not necessary. Ms. Bigglestone stated that insurance regulators of RRGs have certain flexibility in applying actions related to RBC. However, she said RBC is still calculated and is a useful indicator when looking at the overall financial position of an RRG. She also noted that the indicators in the non-troubled worksheet are used as a tool for analysts to help determine the extent of analysis necessary. If they are not triggered, the analyst can choose not to perform additional review in that quarter. If they are triggered, the analyst can choose between performing a full quarterly review or providing an explanation of what caused the trigger and why a full quarterly review is not considered necessary. Therefore, the impact of removing the RRG exception appears to provide additional information without unwarranted additional work and aligns with current regulatory practices.

Mr. O'Donnell and Mr. Matthews stated they did not have concerns and agreed the update aligns with current regulatory practices. Ms. Bigglestone asked NAIC staff to draft a referral to the Financial Analysis Solvency Tools (E) Working Group for the Task Force to consider during its next meeting.

4. **Discussed the RRG Survey**

Ms. Bigglestone stated that last fall, the Task Force drafted and exposed survey questions that are intended to help inform the future direction of the Task Force. Minor edits were incorporated as a result of the exposure period, and the survey was sent to state insurance regulators in February. The survey is currently outstanding with a due date of March 1. Ms. Bigglestone stated that the results of the survey will be aggregated, with the details or state-identifying information kept confidential. The Task Force will then consider the aggregated results to help determine next steps.

5. **Discussed Training Initiatives**

Ms. Bigglestone stated that one element of the Task Force’s charges is to consider educational opportunities that relate to RRG resources for both domiciliary and non-domiciliary states. One way the Task Force is pursuing to satisfy this element of the charges is to conduct a training session during the NAIC’s Insurance Summit. She recommended both domiciliary and non-domiciliary state insurance regulators be alert to the schedule when it is announced and register if they are able.

Having no further business, the Risk Retention Group (E) Task Force adjourned.
The Risk Retention Group (E) Task Force conducted an e-vote that concluded Feb. 5, 2021. The following Task Force members participated: Michael S. Pieciak, Chair, represented by Sandra Bigglestone (VT); Karima M. Woods, Vice Chair, represented by Sean O’Donnell (DC); Andrew N. Mais represented by Fenhua Liu (CT); Sharon P. Clark (KY); Troy Downing represented by Steve Matthews (MT); and Russell Toal (NM).

1. **Approved the Distribution of a Survey for Non-Domiciliary and Domiciliary RRG Regulators**

The Task Force conducted an e-vote to approve the distribution of a survey to state insurance regulators with the purpose to provide the Task Force with insight into future improvements and priorities in the areas of risk retention group (RRG) regulation, registration and training. Mr. O’Donnell made a motion, seconded by Commissioner Clark, to distribute the survey (Attachment One-A). The motion passed unanimously.

Having no further business, the Risk Retention Group (E) Task Force adjourned.
NAIC Risk Retention (E) Task Force
Proposed Survey Questions
Updated February 1, 2021

Purpose: Identify what is working well and what areas the Task Force can improve related to both non-domiciliary and domiciliary regulation of risk retention groups.

Instructions:
Domiciliary states – Please complete both the domiciliary regulator questions and non-domiciliary regulator questions. If different people are responsible for each function, please coordinate internally and two separate submissions may be made. All states should also complete questions not specifically designated as domiciliary or non-domiciliary.

Non-domiciliary states – Please complete questions designated for non-domiciliary states. All states should also complete questions not specifically designated as domiciliary or non-domiciliary.

Note: Individual responses will be kept confidential by NAIC staff. Aggregate information regarding the survey will be compiled, with state specific information and identifying details eliminated for sharing with regulators and/or industry.

1) Name
2) State
3) Email

4) Does your state license domestic risk retention groups?
   a. Yes, as captive insurers
   b. Yes, as traditional insurers
   c. Yes, as both captive and traditional insurers
   d. No
   Comment box: Please provide additional comments.

5) Has your state implemented and provided access to the Best Practices and FAQs for Risk Retention Groups to: 1) - employees in your state responsible for registering or licensing RRGs; 2) - RRGs licensed or registered in your state; 3) - the general public? (referenced documents can be found on the RRGTF webpage under Related Documents https://content.naic.org/cmte_e_risk_retention_group_tf.htm)
   a. No
   b. No, we believe further revisions are required
   c. Yes, via the state website
   d. Yes, via reference to the NAIC website
   e. Yes, via other means
   f. Yes, internally only
   g. Unsure
   Comment box: Please provide additional comments.

6) (Non-Domiciliary Regulators) Has your state implemented the NAIC’s revised Uniform Risk Retention Group Registration Form adopted in 2020 by the C Committee?
   a. No, I was not aware of the revised form
   b. No, but we intend to implement the revised form
c. No, we believe the form requires further revision
d. No, we don’t intend to implement the revised form
e. Yes, and we have received a registration notification
f. Yes, but we have not yet received a registration notification
g. NA
Comment box: Please provide additional comments.

7) (Non-Domiciliary Regulators) Describe your state’s requirements and procedures/processes for the registration of a non-domiciliary RRG in your state.
   a. Comment box

8) (Non-Domiciliary Regulators) As a result of the NAIC’s revised Uniform Risk Retention Group Registration Form, and the Best Practices and FAQ documents, has your state implemented new or additional means of communicating/making inquiries with RRG domiciliary regulators as part of the registration process or annual review process?
   a. Yes
   b. No
   c. NA
   Comment box: Please provide additional comments on new or additional means of communication.

9) (Non-Domiciliary Regulators) Do you believe RRGs applying for registration in your state are properly completing the registration form and providing all required information?
   a. Yes
   b. No
   c. NA
   Comment box: If no, please provide additional comments.

10) (Non-Domiciliary Regulators) When communicating with a domiciliary regulator, did you receive timely responses and were the responses satisfactory?
    a. No, responses were not timely or satisfactory
    b. Responses were timely, but not satisfactory
    c. Responses were satisfactory, but not timely
    d. Yes, responses were both timely and satisfactory
    e. NA
    Comment box: Please comment on what could be improved, if anything?

11) (Domiciliary Regulators) Have you seen an increase in communication received from non-domiciliary states regarding RRGs?
    a. No, unchanged
    b. Yes, minimal increase
    c. Yes, moderate increase
    d. Yes, significant change
    e. NA
    Comment box: Please provide additional comments.

12) (Domiciliary Regulators) If an RRG becomes troubled or potentially troubled do you notify the states it is registered in?
    a. Yes
    b. No
c. Unsure  
d. NA  
Comment box: Please provide additional comments.

13) (Domiciliary Regulators) If an RRG is no longer eligible to write in other states (voluntary or involuntary liquidation, regulatory action, etc.) do you notify the states it is registered in?  
a. Yes  
b. No  
c. Unsure  
d. NA  
Comment box: If yes, please describe the notification/communication process with other states.

14) What areas of the updated tools (NAIC’s revised Uniform Risk Retention Group Registration Form, and the Best Practices and FAQ documents) do you find most beneficial in your regulatory role (what is working well)?

15) What parts of the registration process for non-domestic RRGs do you feel need further clarification, improvement, expanded guidance (what is not working well)?

16) Do you have suggestions for the NAIC RRG Task Force to consider focusing on to keep moving forward with improvements or additional tools and resources (for example – communication considerations, common problem areas, information gaps with other states or the industry, etc.)?

17) What other topics should the NAIC RRG Task Force focus on to further improve and bring more uniformity to the licensing and registration processes, improve the ongoing regulation of RRGs, and/or further improve the understanding of RRGs?

18) Would individuals from your state participate if a webinar or other training is offered covering RRG registration, licensing or other RRG hot topics?  
a. No  
b. Yes, from a non-domiciliary regulator perspective  
c. Yes, from a domiciliary regulator perspective  
d. Yes, from both a non-domiciliary and domiciliary regulator perspective  
Comment box: Please comment on what topics would be helpful.

19) What suggestions do you have to best disseminate information on RRG regulation to state regulators (both domiciliary and non-domiciliary)?

20) Do you utilize the NAIC Risk Retention and Purchasing Group Handbook?  
a. Yes  
b. No

21) Do you have suggestions for updating and improving the NAIC Risk Retention and Purchasing Group Handbook?  
a. Yes  
b. No  
Comment box: If yes, please provide suggestions.
22) (Domiciliary Regulators) Do you utilize the UCAA for licensing new Risk Retention Groups?
   a. Yes
   b. No
   c. NA

23) (Domiciliary Regulators) If you use a process other than UCAA for licensing new Risk Retention Groups, please check all the following elements that are part of the process to charter/license a new RRG.
   a. Background checks and use of biographical affidavit forms
   b. Use of a consulting actuary to review the plan of operation, feasibility analysis and financial projections
   c. Review and evaluation of management personnel
   d. Review of related parties, MGUs and service providers
   e. Review of corporate documents
   f. Review of corporate governance procedures and guidelines
   g. Review of plan of operation, including risks to be insured, limits and maximum retained risk
   h. Review of feasibility study, including financial projections
   i. Require the RRG to list the states the RRG proposes to register in
   j. Require the RRG to include a description of any permitted practice requests
   k. Review of the reinsurance program and creditworthiness of proposed reinsurers
   l. Review of the investment policy and custodial arrangement/agreement
   m. Review of the capital structure, and if applicable, form of surplus note or letter of credit
   n. Review of ownership (including financial information of owners/members) and form of shareholder/subscriber agreements
   o. Review of rates, policy forms and underwriting guidelines, and if applicable, comparison of rates in states proposed to operate in
   p. Review of risk mitigation and loss prevention measures
   q. Review of prospective risks
   r. Review for compliance with the Federal Liability Risk Retention Act
   s. Review for compliance with holding company regulations
   t. Review of marketing materials
   u. NA

Comment box: Please provide a discussion of other key elements or relevant timelines of the licensing process not identified above.
VALUATION OF SECURITIES (E) TASK FORCE

Valuation of Securities (E) Task Force March 22, 2021, Minutes .......................................................... 10-1007
Valuation of Securities (E) Task Force Feb. 18, 2021, Minutes (Attachment One) .................................. 10-1015
Valuation of Securities (E) Task Force Dec. 18, 2020, Minutes (Attachment Two) ............................. 10-1021
Memorandum Regarding Proposed Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to Update the List of NAIC CRPs (Attachment Four) .................. 10-1048
Valuation of Securities (E) Task Force
Virtual Meeting (in lieu of meeting at the 2021 Spring National Meeting)
March 22, 2021

The Valuation of Securities (E) Task Force met March 22, 2021. The following Task Force members participated: Dana Popish Severinghaus, Chair, represented by Kevin Fry (IL); Doug Ommen, Vice Chair, represented by Carrie Mears (IA); Lori K. Wing-Heier represented by Wally Thomas (AK); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kathy Belfi (CT); Trinidad Navarro represented by Rylynn Brown (DE); David Altmaier represented by Carolyn Morgan and Ray Spudeck (FL); Dean L. Cameron represented by Eric Fletcher (ID); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Stewart Guerin (LA); Gary D. Anderson represented by John Turchi (MA); Kathleen A. Birrane represented by Matt Kozak (MD); Chlora Lindley-Myers represented by Debbie Doggett (MO); Bruce R. Ramge represented by Lindsay Crawford (NE); Marlene Caride represented by Nakia Reid and John Sirovetz (NJ); Linda A. Lacewell represented by Jim Everett (NY); Doug Slape represented by Amy Garcia (TX); Jonathan T. Pike represented by Jake Garn (UT); Mike Kreidler represented by John Jacobson (WA); and Mark Afable represented by Randy Milquet (WI). Also participating was: Dale Bruggeman (OH).

1. **Adopted its Feb. 18, 2021; Dec. 18, 2020; and 2020 Fall National Meeting Minutes**

The Task Force met Feb. 18, 2021; Dec. 18, 2020; and Nov. 18, 2020. During its Feb. 18, 2021, meeting, the Task Force took the following action: 1) received a proposed amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to update the financial modeling instructions for residential mortgage-based securities (RMBS)/commercial mortgage-based securities (CMBS); 2) discussed comments received and adopted a proposed amendment to the P&P Manual to update the list of NAIC credit rating providers (CRPs) to reflect nationally recognized statistical rating organization (NRSRO) changes; and 3) received a referral from the Statutory Accounting Principles (E) Working Group on nonconforming credit tenant loans (CTLs); 4) received a proposal to the P&P Manual to update the list of NAIC credit rating providers (CRPs) to reflect nationally recognized statistical rating organization (NRSRO) changes; and 5) discussed U.S. Securities and Exchange Commission (SEC) Rule 18f-4 under the federal Investment Company Act of 1940 related to the use of derivatives by registered investment companies. During its Dec. 18, 2020, meeting, the Task Force took the following action: 1) exposed an updated amendment to the P&P Manual to include instructions for financially modeled RMBS/CMBS to map NAIC designation categories for a three-day public comment period ending Dec. 22, 2020; and 2) discussed financially modeled RMBS/CMBS price breakpoints and other issues surrounding securities that have a zero-loss in 2020.

Mr. Thomas made a motion, seconded by Ms. Clements, to adopt the Task Force’s Feb. 18, 2021 (Attachment One); Dec. 18, 2020 (Attachment Two); and Nov. 18, 2020 (see NAIC Proceedings – Fall 2020, Valuation of Securities (E) Task Force) minutes. The motion passed unanimously.

2. **Adopted an Amendment to the P&P Manual to Update the Financial Modeling Instructions for RMBS/CMBS Securities**

Mr. Fry said at the end of last year, there were some unusual results through the financial modeling process due to the economic scenarios. It produced more securities with losses that were previously zero loss securities that now needed to use the price breakpoint methodology. Coupled with lower interest rates, these securities also traded at a premium. The Task Force did some work last year to temporarily fix the issues with the price breakpoint methodology for year-end 2020, and it was agreed that a longer-term fix was necessary. In front of the Task Force now is that fix to the price breakpoint methodology for securities prior to 2013 and for securities after 2013—move away from price breakpoints and use more of a single-designation process.

Eric Kolchinsky (NAIC) said the proposed amendment P&P Manual is to move to two types of information. For legacy securities, those prior to 2013, the Task Force will continue to provide breakpoints for more post-crisis securities. The process of calculating the expected losses would be the same, except now, instead of converting the intrinsic price into breakpoints, it would be converted into a designation for non-legacy securities—those after 2013. The Structured Securities Group (SSG) believes it to be a good approach to minimize the convexity experienced in the zero loss securities and standardize reporting. The SSG would like to implement this for year-end but realizes that there may be some technical issues for the NAIC and application vendors. Therefore, it is open to a potential 2022 implementation.

Mr. Fry said the Task Force will be in a better position later this year to know whether it can implement by year-end 2021 or if a 2022 implementation is needed, which will give more than enough time.
Discussed Comments Received for an Updated Proposed Amendment to the P&P Manual to Require the Filing of Private Rating Letter Rationale Reports

Mr. Fry said the next item on the agenda is to discuss comments received on a proposed amendment to require the filing of private rating letter rationale reports. The Securities Valuation Office (SVO) worked with the ACLI, NASVA and the Private Placement Investors Association (PPIA) to update the amendment and resolve some of the operational issues that were raised during the Task Force’s Feb. 18 meeting. Mr. Fry asked Mr. Therriault to review the updated amendment.

Mr. Therriault said this proposed amendment would require the rating rationale report to be filed with the SVO for privately rated securities. The rating rationale report should provide a more in-depth analysis of the transaction structure, the methodology used to arrive at the private rating, and, as appropriate, a discussion of the transaction’s credit, legal and operational risks and mitigants. With both the private rating letter and the private rating letter rationale report, the SVO will be able to better understand the security.

During the Task Force’s Feb. 18 meeting, interested parties raised several issues. The SVO staff held a follow-up meeting with the ACLI, NASVA and the PPIA on Feb. 22 to discuss the issues and revise the amendment based on that discussion. They
also met March 4, March 18 and March 19 to review the changes and receive further feedback. The updated amendment reflects many, but not all, of the changes. Summarizing the changes that are in in the revised amendment, the first change was to the transition language in paragraph 11 to permit an option to companies that cannot provide the ratings rationale due to confidentiality or contractual reasons. The next issue, which was an extended discussion during the the Task Force’s Feb. 18 meeting, related to the disclosure as to why something was ineligible. An update was made to paragraph 21 for a new brief disclosure visible to all filers in VISION for two specific situations: 1) the security type is ineligible for filing exemption (FE) according to the P&P Manual list of “Specific Populations of Securities Not Eligible for Filing Exemption”; or 2) the security is of a type outside the scope of Statement of Statutory Accounting Principles (SSAP) No. 26R—Bonds, SSAP No. 32R—Preferred Stock or SSAP No. 43R—Loan Backed and Structured Securities, which would also make it ineligible for FE. This requires a VISION technology change, and it has already been added to the development queue. The last update was to paragraph 22 to provide a reporting option if the private rating rationale report cannot be provided for reasons other than confidentiality or contractual limitations after Jan. 1, 2022.

Another issue raised during the Task Force’s Feb. 18 meeting but is not in the updated amendment relates to the required content of the rating rationale report. Rating agencies are in the business of publishing credit analysis opinions and should be familiar with what they typically publish for a specific asset type. The SVO is expecting something comparable to their public reports. Rating agencies often mention that their private ratings are equivalent to their public ratings in terms of the analysis performed. The SVO is looking for something comparable to the publicly rated securities. It was mentioned possibly using the SVO’s regulatory treatment analysis service (RTAS) letter as a benchmark. That is not a good comparison because it is just a summary of what the reporting treatment would be for the security, but it does not go into an in-depth analysis of the credit or methodology. There are few changes that still need to be made to the amendment and worked through with the ACLI, NASVA and the PPiA, specifically to the transition period and confidentiality provisions. With the Task Force’s permission, the SVO would like to continue working with industry and expose a clean version of the amendment with those revisions and expose it for a short public comment period.

Sasha Kamper (PPiA) said there have been multiple meetings to discuss this amendment and agreed in concept during March 19’s meeting to a workable solution. There are a few more changes needed to the amendment that will lay out some of those details.

Mr. Fry directed the SVO to continue working with industry on the amendment to require the filing of private rating letter rationale reports with the SVO and expose a clean version of the amendment, when it is ready, for a 30-day public comment period.

4. Adopted an Amendment to the P&P Manual to Update the List of NAIC CRPs to Reflect NRSRO Changes

Mr. Fry said this agenda item is to discuss comments received and consider for adoption a proposed amendment to update the list of CRPs to reflect NRSRO changes. The proposed amendment reflects the merger of Morningstar and DBRS, and the name update for the Kroll Bond Rating Agency LLC.

Ms. Kamper asked for clarification. She asked if this amendment is to recognize the merger of DBRS and Morningstar or the Kroll Bond Rating Agency name change. Mr. Therriault said on the original exposure, there was a different name for Kroll Bond Rating Agency, which was what was reflected on SEC’s Office of Credit Rating (OCR) website. The amendment was revised to correct Kroll’s name to reflect what is on their Form NRSRO. The rest of the amendment relates to the DBRS/Morningstar merger and a few other minor CRP name changes. Kroll was only highlighted because it was a change from the last time this amendment was discussed by the Task Force.

Mr. Thomas made a motion, seconded by Ms. Mears, to adopt the amendment to the P&P Manual to update the list of NAIC CRPs to reflect NRSRO changes (Attachment Four). The motion passed unanimously.

5. Received a Request from the ACLI to Study the National Financial Presentation Standard for Spanish GAAP.

Mr. Fry said the next agenda item is to receive a request from the ACLI to study the national financial presentation standard for Spanish generally accepted accounting principles (GAAP). The ACLI submitted a letter dated March 1 initiating this formal request for a review by the SVO as required in Part Two of the P&P Manual. In discussions with the SVO staff, the ACLI letter satisfies the pre-condition necessary to conduct the requested study, and the SVO is ready to begin.

Mr. Monahan said that two large multinational companies have asked to have the SVO study Spain as a national financial reporting standard. The SVO has a great process in place for such a review. The ACLI is close to signing the contract with an
accounting firm to assist with the study, and it just needed the Task Force’s approval to undertake the study. The accounting partners will not be flying to the U.S. to meet at the SVO office and instead will be meeting virtually via Zoom or RingCentral.

Mr. Fry said this is informational only; no action is required by the Task Force at this time. When the SVO concludes the study, the SVO will report back to the Task Force with their findings, recommendation and, if appropriate, a possible amendment.

6. Discussed and Received a Proposed Amendment to the P&P Manual to Clarify Guidance for Fund Leverage

Mr. Fry said the next agenda item is to discuss and receive a proposed amendment to the P&P Manual to clarify guidance for fund leverage. Mr. Fry asked Marc Perlman (NAIC) to provide a summary.

Mr. Perlman said the P&P Manual currently grants the SVO discretion when determining whether a fund’s use of derivatives is consistent with a fixed income like security, meaning it will generate predictable and periodic cash flows and is, therefore, eligible for an NAIC designation. Recognizing that this discretion regarding the use of derivatives by funds can lead to a possible lack of predictability when a fund is submitted to the SVO for potential inclusion on its fund lists, some members of the Task Force requested the SVO propose a P&P Manual amendment that would create a more predictable bright line test.

As explained during the Task Force’s Feb. 18 meeting, the SEC adopted a final version of Rule 18f-4 last year, which allows funds to enter into derivative transactions, notwithstanding the federal Investment Company Act’s restrictions of them, so long as funds meet certain conditions. The SVO focuses most closely on the exception to these requirements for limited users of derivatives, meaning funds that limit their exposure to derivatives with potential risk of future payment or loss (call it downside risk) to 10% or less of net assets, exclusive of certain derivatives used to hedge certain currency and interest rate risks. The SEC recognized the risk that derivative transactions pose to funds because they involve leverage or the potential for leverage, which can magnify gains and losses compared to the fund’s investment, while also obligating the fund to make a payment or deliver assets to a counterparty under specified future conditions. The SVO contends that such leverage is inconsistent with the predictable and periodic standard in the P&P Manual. As such, the SVOs recommend using Rule 18f-4’s limited user standards as a kind of guidepost for creating the requested bright line test in the P&P Manual.

Specifically, the SVO is proposing two new tests. Test No. 1: For funds on the SVO-identified Bond ETF List, the SVO-identified Preferred Stock ETF List and the NAIC List of Schedule BA Non-Registered Private Funds with Underlying Assets Having Characteristics of Bonds or Preferred Stock (each of which is granted bond treatment on their respective reporting schedules), the SVO proposes a similar, but not identical, threshold to the limited user exception in Rule 18f-4, whereby the gross notional amount of derivatives that impose no future payment or margin posting obligation on the fund (meaning there is no future “downside” risk), cannot exceed 10% of the net asset value of the fund, except for (and these are the exclusions from the 10% calculation) derivatives that are either used by funds to create more bond-like cash flows or that are common for maintenance of fund portfolios. These acceptable exemptions would include: 1) certain currency and interest rate hedges on fixed-income or preferred stock in the fund portfolio; 2) certain futures or forwards on fixed-income or preferred stock to be held in the fund’s portfolio and for which money for the future purchase have been set aside; 3) reserve-repurchase agreements associated with specific fixed income or preferred stock investments held by the fund; and 4) non-margin borrowing for purposes other than investment. While this first test, like the SEC’s, caps derivatives at 10% of net asset value (NAV), the SEC only caps derivatives with future payment or downside risk. The SVO proposes not permitting any derivatives with future payment or downside risk, other than the exempt derivatives just listed, and capping derivatives with only upside potential at 10%. The reason for capping derivatives with only potential gain for the fund is that they are speculative and, therefore, do not meet the periodic and predictable standard.

Test No. 2: Funds on the NAIC Fixed Income-Like SEC Registered Funds List are in scope of SSAP No. 30R—Unaffiliated Common Stock and reported on Schedule D, Part 2, Section 2. Based on such reporting, if the Task Force deems it appropriate, NAIC designations assigned to those funds could be permitted to include assessments of risk other than credit risk, including market and liquidity risk—both risks introduced by derivatives. This also addresses requests by several Task Force members that a wider range of funds be eligible to receive an NAIC designation. Therefore, if the Task Force thinks it appropriate, these funds could be permitted a larger derivative threshold of up to 20% of the NAV of the fund, but, unlike the first test, with no exempt derivatives. This threshold would also prevent violation of the P&P Manual fund methodology’s predominantly hold requirement that a fund will hold at least 80% of its assets in bonds or preferred stock, depending on the type of fund. For both tests, the SVO recommends incorporating an assessment of counterparty risk into its credit risk assessment. It should also be noted that these increased thresholds for derivatives might not be acceptable under certain state laws. For example, a bill under consideration in New York would cap funds’ non-reserve investments at 10%, meaning derivatives would likely be capped at that amount.

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The SVO thinks the two tests would achieve the goal of greater clarity and predictability to fund sponsors and investors regarding the SVO’s fund reviews while still maintaining the P&P Manual’s predictable and periodic standard. Though, it should be noted, the two tests would be more generous than the current approach in that some speculative derivatives would be permitted. While the second test may permit additional funds on the NAIC Fixed Income-Like SEC Registered Funds List, the inconsistent, and possibly punitive, RBC treatment of funds on this list versus other funds with NAIC designations is not something that the Task Force can address directly. For example, exchange-traded funds (ETFs) on the NAIC Fixed Income-Like SEC Registered Funds List would have a different RBC treatment from ETFs on the SVO Identified Bond or Preferred Stock ETF Lists. For this reason, the Task Force might consider a referral to the Capital Adequacy (E) Task Force and the Financial Condition (E) Committee requesting the assignment of bond RBC factors for all funds whose credit risk has been assessed by the SVO and assigned an NAIC designation pursuant to the Task Force’s policies, including the NAIC Fixed Income-Like SEC Registered Funds List. This would be similar to the referral the Task Force made to the Capital Adequacy (E) Task Force in 2018. Equalizing the RBC treatment for assets with similar credit risk, represented by the SVO assigned NAIC designation, would provide a consistent and uniform NAIC process consistent with regulatory needs for funds. With these amendments the Task Force would be redefining what goes on the NAIC fund lists and, therefore, redefining the fund asset. Therefore, it would be appropriate to refer the proposed amendment to the Statutory Accounting Principles (E) Working Group.

Additionally, the SVO is proposing to add an assessment of a fund’s management to the fund methodology. Under this assessment, the SVO would have the ability to consider a fund’s management and organization, including: 1) key-man risk; 2) its risk management and compliance infrastructure; 3) its credit management standards and credit research capabilities; and 4) its derivatives risk management program for funds required to have one under Rule 18f-4. Based on the management assessment, the SVO would be able to notch down from its credit risk assessment or choose not to assign an NAIC designation.

Mr. Everett asked states have defined their bond treatment by NAIC treatment. “Speculative” was mentioned regarding certain funds. Does the SVO know what funds those are? And if states permit these to be used for surplus, that would seem to be a departure. What is being defined as “speculative”? Mr. Perlman said “speculative” is anything with leverage where a fund can have outsized gains or losses. What the SVO is proposing—except for the exempt derivatives discussed, which are derivatives hedging certain risks on assets within the fund portfolio, but other than those preventing risks—where there is potential loss or future payment obligations, capping those with the potentially unlimited upside gain because the P&P Manual has the predictable and periodic standard to be bond-like.

Mr. Everett asked how many states that permit bond ETFs for primary capital surplus may be affected. Mr. Therriault said given the definition change, putting a 10% speculative threshold for those that are on the bond or preferred stock ETF lists, the change is not expected to have any impact for those lists. The threshold is generally consistent with the ETF list today. The other test is a little more generous for the SEC registered fund list, which is reported on the common stock schedule.

Mr. Everett asked if it would it be the Statutory Accounting Principles (E) Working Group or this Task Force that would be looking at standards for the management assessment. Mr. Perlman said the SVO would do that. Mr. Fry said this would be just another thing the SVO assesses in the whole package of things assessed with funds.

Mr. Fry directed the SVO to expose this amendment to the P&P Manual to clarify Guidance for Fund Leverage for a 45-day public comment period ending May 6, 2021, and make a referral to the Statutory Accounting Principles (E) Working Group requesting their approval of the proposed changes to these definitions.

7. Received a Staff Report on Projects Before the Statutory Accounting Principles (E) Working Group

Mr. Fry said the next agenda item is to hear a report on projects before the Statutory Accounting Principles (E) Working Group. Mr. Fry asked Julie Gann (NAIC) to provide that report.

Ms. Gann said there were a few things to highlight from the Statutory Accounting Principles (E) Working Group’s March 15 meeting. She said that while the Working Group adopted several items and exposed several items, this update will only highlight four adoptions and two exposures. For the adoptions, the Working Group:

- Incorporated revisions to clarify that publicly traded preferred stock warrants should be treated as preferred stock. This is something similar to what was already in place for publicly traded common stock warrants to be treated as common stock. The reason it is required to be specified is all other warrants are captured as derivatives in the scope of SSAP No.86—Derivatives. The Working Group had not seen those preferred stock publicly traded warrants before, but they are out there, so the guidance was clarified accordingly.
- Adopted revisions to indicate the changes to the Freddie Mac Structured Agency Credit Risk (STACR) and Fannie Mae Connecticut Avenue Securities (CAS) programs, which will be issued through REMIC, which is a REMIC trust, will still be in scope of SSAP No. 43R, and those revisions align the financial model guidance to match the P&P Manual.
- Clarified that perpetual bonds with an effective call option shall be amortized, using the yield to worst method with all other perpetual bonds that do not have an effective call option to be reported at fair value.
- Incorporated guidance and new disclosures to ensure that all related parties, including those with over a 10% ownership that may have disclaimed affiliation, are still reported as related parties in the financial statements. There is also a new schedule Y Part 3 to detail age-related parties.

Regarding exposures, Ms. Gann said comments are due April 30. She reiterated that while the Working Group exposed a long list of items, she will highlight only two of them. The Working Group exposed:

- Exposed revisions to data capture and expanded disclosures in SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities to make it easier to identify when an insurer has transferred an asset and maintains continuing involvement, such as with a self-securitization. There are existing disclosures in SSAP No. 103R, but they are currently in the narrative. It is not possible to aggregate and assess those transactions or to see problems. That is one of the main goals of this new disclosure.
- Exposed a proposed interpretation to clarify that cryptocurrency such as Bitcoin does not meet the definition of cash and is a non-admitted asset under statutory accounting. With that exposure, the Working Group requested for industry to provide information regarding the extent that insurers hold cryptocurrency.

Ms. Gann said the Working Group plans to meet May 20 to hear comments on those exposed items and take action, particularly with regards to those that have blanks-related revisions.

Ms. Gann said the Working Group also discussed the SSAP No. 43R project. She said there has been a small group of industry that has been meeting with Iowa and NAIC staff weekly since Fall 2020. The initiative is to draft a definition of what should be captured as a bond on Schedule D-1. The project was undertaken as an initial first step in the 43R substantive project as it was identified that some investments that caused regulator concern are not necessarily limited to SSAP No. 43R, and they could have been either captured or reclassified to SSAP No. 26R. By identifying what should be captured as a bond first, the project removes the concern of potential reclassification for those investments. The small group has made significant progress in drafting this definition, and it is anticipated that this preliminary definition will be publicly exposed by the end of May, possibly in accordance with the Working Group’s May 20 meeting.

Ms. Gann added that the draft definition currently focuses on investments that reflect issuer credit obligations and asset backed securities. It establishes definitions and criteria of what should be captured within both classifications. Once the definition has been publicly discussed, it is anticipated that SSAP revisions will occur to incorporate the definitional concepts. Those are currently anticipated to occur within SSAP No. 26R and SSAP No. 43R; future discussions will determine the best approach. She said it is also anticipated the investments that no longer qualify for D-1 will move to Schedule BA. It is anticipated that the discussions will include accounting and reporting concepts for those investments and that referrals will be sent to the Capital Adequacy (E) Task Force to determine RBC.

Ms. Gann said the Working Group has received questions regarding CTLs and how the current project for D-1 assessment will affect that specific investment. These questions also asked about the purpose of the prior referral that the Working Group sent to the Task Force. To provide some clarity on this situation, there are two workstreams: 1) the Statutory Accounting Principles (E) Working Group project on the D-1 bond definition; and 2) the Valuation of Securities (E) Task Force project to revisit the structural requirements that are in the P&P Manual. It is anticipated that these will ultimately converge. However, with the specific discussion on CTLs last fall, specific focus is being given to these investments concurrently with the bond project. The determination of whether an investment qualifies within an SSAP and a particular reporting schedule is a decision of the Statutory Accounting Principles (E) Working Group. However, in certain cases, such as with CTLs, a structural analysis by the SVO under the requirements of the P&P Manual is necessary to satisfy this requirement. The original determination of residual risk allowing the reporting on Schedule D was made by the Invested Asset (E) Working Group, which has since been disbanded. Since that residual risk threshold is currently housed in the P&P Manual and information on the CTLs filed with the NAIC is reviewed by the Task Force, the prior referral intends to solicit the expertise of the Task Force and the NAIC SVO staff from their knowledge of those filed CTLs, which includes an assessment of whether that residual risk threshold should be revised. Both the structural parameters and the ultimate role of the structural analysis in relation to the principles developed through the Statutory Accounting Principles (E) Working Group bond project will require coordination between both groups as these
projects progress. Statutory Accounting Principles (E) Working Group staff will continue to work closely with the Valuation of Securities (E) Task Force staff regarding those investments.

8. Heard an Update on CTLs

Mr. Fry said he would cover the CTL update next. The Statutory Accounting Principles (E) Working Group recently did an interpretation on CTLs that are called nonconforming CTLs and have a rating agency rating. These could be reported on Schedule D for year-end 2020 as long as they were filed with the SVO before Feb. 15, 2021. These securities were also required to be listed in the notes of the financial statement for year-end 2020. It was agreed that if the SVO assigns a designation to these securities, they would be allowed to be reported on Schedule D through the third quarter of 2021. The reason why the Working Group selected that date was that it was anticipated by then that the SSAP No. 43R project would provide a framework that would address these securities. If that framework has not been provided by that time, it might be possible for an extension of that policy until the SSAP No. 43R project matures. The SVO is committed to applying its methodology for CTLs or any other securities that have a residual risk up to 50%. If that residual risk is over 50%, on a case-by-case basis, the SVO would assess whether there are enough mitigating factors to designate these securities. The SVO is looking at the securities that were filed for last year-end. If there are any new securities in the market, the SVO will look at those it can designate. A designation does not mean that it goes on a specific schedule; that is the Statutory Accounting Principles (E) Working Group’s responsibility. If the SVO designates one of these and Statutory Accounting Principles (E) Working Group decides that it is not eligible for bond treatment on Schedule D, there may still be a Schedule BA home for these with fixed income like RBC, provided the Capital Adequacy (E) Task Force and everyone else signs off on this treatment.

Ms. Belfi said there was a lot of confusion on direction from some of the interested parties and Task Force members. Hopefully, there will be a resolution. Mr. Everett said if this unfreezes the market, then the Task Force is moving in the right direction.

Tom Sargent (Waterway Capital), representing the Lease-Backed Securities Industry Group, asked how Mr. Fry sees this moving forward. He asked, “If there is a CTL with a residual in the neighborhood of 20% to 50%, do we proceed in placing that in front of the SVO to get a designation?” Mr. Fry said it should be filed with the SVO as it has been looking at the ones that came in last at the end of last year, and the SVO will use that same methodology. This is a new area, looking at ones where there is a greater that 5% residual. The SVO is in a position where it is looking at them through 50%, verifying the structure and then looking through to the lessor. The SVO is going to look at those that will need mitigating factors. There is the project before the Statutory Accounting Principles (E) Working Group, and as that framework becomes more mature, everything will come together by the end of the year.

Mr. Sargent asked if they should be submitted as an RTAS. Mr. Theriault said insurers can be submit them to the SVO as a regular filing. The SVO did receive 21 filings that were identified as nonconforming by the Feb. 15 deadline. There were an additional 27 filings that have not been reviewed but were submitted by the deadline. Any direction the SVO receives from the Task Force, including accepting additional residual risk, will be taken into consideration during the SVO’s assessment, but the rest of the CTL criteria would still apply.

Mr. Sargent asked if the definition of “residual risk” was using the original loan balance or the appraised loan to value. Mr. Perlman said it would be the loan balance.

Mr. Bruggeman asked that since the Statutory Accounting Principles (E) Working Group sent over the letter to evaluate the old 5% threshold, is 50% the new standard or is that still ongoing, and is the SVO still evaluating it. Mr. Fry said the SVO can safely go to 50% in this interim period and can look at ones higher, but they will need other mitigating factors. The Task Force will formally change it in the P&P Manual up to the 50% mark once the interim solution becomes permanent. Mr. Bruggeman asked if the 50% is temporary just as the SVO is going through the process for the year-end files and then the Task Force will evaluate whether to make it permanent. Mr. Fry said that is right and probably any new securities so that the market is not frozen. They will still be at the mercy of the Statutory Accounting Principles (E) Working Group ruling and if they do not belong on the bond schedule, they will likely end up with a Schedule BA and will still need to go through the Capital Adequacy (E) Task Force to get RBC certainty.

Mr. KozakMD asked if there was a potential that some of this would go on Schedule B as opposed to Schedule BA. Mr. Fry said that is not completely off the table. As the SSAP No. 43R project plays out, there will be some things that are in or out. If they are not in scope of SSAP No. 43R, it is possible one could consider those going on Schedule B. Some people may also see them on Schedule BA with a designation for fixed income, but that is only available to life insurers and fraternal insurers. That would not be available to the property/casualty (P/C) insurers. Ms. Gann said it really depends on the structure of the investment. If it is not a security, then technically it would go on the mortgage loan schedule, which is Schedule B. The ones
that are securities are where there may be a gray area, whether they should be SSAP No. 43R or Schedule BA. All of this is expected to be discussed further as part of the bond project.

Mr. Therriault said as the SVO receives filings with increasing amounts of residual exposure, the SVO will need additional documentation on the property because that additional component will now need to be assessed. This will be additional documentation beyond what is currently identified in the P&P Manual now.

9. Received a Report from SVO on Year-End Carry-Over Filings

Mr. Fry said once a year, the SVO gives the Task Force an update on its backlog and how that is looking. Mr. Fry asked Mr. Therriault for a quick update on that.

Mr. Therriault said for 2020, the SVO reviewed 12,696 filings comprised of: 3,092 initial filings; 7,866 annual updates; 1,209 additional issuances; and 529 other filing types. The total filing numbers included 2,027 manually processed private rating letters. For year-end 2020, there were 795 carry-over filings, 351 that received an “IF” for an accepted initial filing and 444 that received a “YE” for an accepted annual update. This was a carry-over rate of 6.3% for 2020, well below the rate of 10% or higher that the SVO considers concerning or reflective of a resource constraint.

As of March 16, there were only 70 remaining carry-over filings, 45 accepted initial filings and 25 accepted annual update filings. The remaining carry-over rate was 0.6% as of that date and has only gotten lower since then. This was an impressive performance by the SVO staff and managers given the significant disruptions introduced by working 100% remotely starting March 10, 2020, along with the team absorbing the new analytical work related to ground lease financing (GLF) transactions. At this time, Mr. Therriault said he is not seeing any SVO analyst resource constraint issues, but there are significant resource limitations with technology support for the office that have affected the SVO’s ability to improve the core systems, VISION, Automated Valuation Service+ (AVS+) and Structured Securities (STS), or fully use the SVO’s investment data. Also, if additional analytical tasks are assigned to the SVO, which the SVO is happy to take on for the Task Force, additional resources may be needed.

Mr. Monahan said a suggestion for the future is to add the report as an attachment, and he thanked and congratulated the SVO for their hard work.

Having no further business, the Valuation of Securities (E) Task Force adjourned.
Valuation of Securities (E) Task Force
Virtual Meeting
February 18, 2021

The Valuation of Securities (E) Task Force met Feb. 18, 2021. The following Task Force members participated: Dana Popish Severinghaus, Chair, represented by Kevin Fry (IL); Doug Ommen, Vice Chair, represented by Carrie Mears (IA); Lori K. Wing-Heier represented by Wally Thomas (AK); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kathy Belfi (CT); Trinidad Navarro represented by Rylynn Brown (DE); David Altmayer represented by Carolyn Morgan and Ray Spudeck (FL); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Stewart Guerin (LA); Gary D. Anderson represented by John Turchi (MA); Kathleen A. Birrane represented by Matt Kozak (MD); Chlora Lindley-Myers represented by Debbie Doggett (MO); Bruce R. Ramge represented by Lindsay Crawford (NE); Marlene Caride represented by John Strovetz (NJ); Linda A. Lacewell represented by Jim Everett (NY); Jessica K. Altman represented by Kimberly Rankin (PA); Texas represented by Amy Garcia (TX); Jonathan T. Pike represented by Jake Garn (UT); Scott A. White represented by Edward Buyalos (VA); Mike Kreidler represented by John Jacobson (WA); and Mark Afable represented by Randy Milquet (WI).

1. Received a Proposed Amendment to the P&P Manual to Update the Financial Modeling Instructions for RMBS/CMBS and Direct IAO Staff to Produce NAIC Designation and NAIC Designation Categories for Non-Legacy Securities

Mr. Fry said the first item on the agenda is an amendment to update the Financial Modeling Instructions of the Purpose and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to move away from using price break points for securities issued after Jan. 1, 2013. The Task Force, through the Structured Securities Group (SSG), will still model everything and use break points up to the cutoff date. Any security issued after that cutoff date would use modeling to produce a single NAIC designation that all insurers would use regardless of their carrying value. This amendment was driven by problems experienced last year with the price break point methodology. During the year-end modeling process, there were more non-zero loss securities because of the modeling scenarios, which then subjected those securities to the price break point process. Given the very low interest rate environment, many of these securities trade at a premium. The combination of all these factors caused some illogical results in securities that were more highly rated than the final results going through the break point methodology. The SSG was able to fix this for year-end by changing its criteria for a non-zero loss security. This was a temporary fix; by year-end, there were still some securities with illogical results, but there were less of them than there would have been. The Task Force agreed at that time that it needed to relook at this process, and the Investment Analysis Office (IAO) staff came back with this amendment. Ideally, it would be good to have this for year-end 2021. The proposed amendment may produce a couple of new symbols that would need to work through with Blanks (E) Working Group.

Eric Kolchinsky (NAIC) said the first thing is that the proposal is separating securities into legacy and non-legacy. The legacy date was chosen just to conform what was already used in the past for securities in Part Four of the P&P Manual. The thinking behind it was the same, and it is better not to have multiple dates for this. Legacy securities will continue to receive the price break points. Those are the securities that were affected by the global financial crisis, and they are far more affected by this process. For newer securities, the proposal would map from the intrinsic price, similar to what is done to the Structured Agency Credit Risk (STACR)/Connecticut Avenue Securities (CAS) type securities, which are issuer obligations. What is being proposed is mapping the non-legacy intrinsic price to the five break point levels currently used for the mortgage reference securities, CAS, and STACR, and providing the NAIC designation for those mapped securities. The proposal is attached, and as things develop in terms of broader risk-based capital (RBC) factors, there will be adjustments. A short comment period is recommended for this proposal so that it can be implemented for year-end 2021 and referred to the Blanks (E) Working Group, if need be. NAIC staff have been working with industry participants on the proposal, as this was a fairly known issue.

Michael M. Monahan (American Council of Life Insurers—ACLI) said the ACLI is very supportive of the 30-day exposure, and it committed to getting this done as efficiently and effectively as possible. There was an ACLI call on Feb. 11 to see where ACLI members were, and the ACLI members are solidly in the camp of Mr. Kolchinsky and the Task Force. Another call is scheduled for tomorrow.

Mr. Fry directed IAO staff to expose this amendment to update the financial modeling instructions for residential mortgage-backed securities (RMBS)/commercial mortgage-backed securities (CMBS) to produce NAIC designation and NAIC designation categories for non-legacy securities for a 30-day public comment period.
2. Discussed Comments Received and Considered for Adoption of a Proposed Amendment to the P&P Manual to Require the Filing of Private Rating Letter Rationale Report

Mr. Fry said the next item is a proposed amendment to require the filing of private rating letter rationale reports along with the private letter ratings. Given industry feedback on this item, it may best to update the amendment and consider it again at the Spring National Meeting. This amendment goes along with the bespoke effort started last year to gain transparency. Getting the rating rationale reports would be a big part of that transparency. Comments were received from industry, and the Securities Valuation Office (SVO) staff has reviewed them.

Charles A. Therriault (NAIC) said this proposal would require the rating rationale report to be filed with the SVO for privately rated securities. The rating rationale report should include a more in-depth analysis of the transaction structure; the methodology used to arrive at the private rating; and, as appropriate, the transaction’s credit, legal and operational risks. With both the private rating letter and the private rating letter rationale report, the SVO will be able to determine whether the private credit rating is an Eligible NAIC Credit Rating Provider (CRP) Rating, meaning the security type is eligible to be reported on Schedule D, and it is appropriate for a nationally recognized statistical rating organization (NRSRO) credit rating to determine the NAIC designation.

A joint comment letter was received from the ACLI, the North American Securities Valuation Association (NASVA), and the Private Placement Investors Association (PPIA). There were several constructive suggestions. The first suggestion relates to the creation of a transition period between when private rating letters were first required for securities issued after Jan. 1, 2018, and the effective date for this new provision, Jan. 1, 2022. SVO staff agree with the recommendations, and the text they proposed to paragraph 11 and 22 in the comment letter, highlighted in blue, provides for a transition period or for a situation where the rating rationale is not submitted.

The joint comment letter also asked for clarification on providing the rating rationale reports for only the initial issuance by the CRP and whether it is required annually. The amendment was structured as an ongoing filing requirement, including any material changes. Many things can happen to an investment after issuance, and the SVO still recommends that this be an ongoing requirement, but that is a decision for the Task Force.

The next recommendation in the comment letter, highlighted in green, introduces a new definition of a security that is ineligible for an NAIC designation. There are extensive definitions already in the P&P Manual devoted to Filing Exemption (FE) eligibility and NAIC designation eligibility. Adding an additional section for only privately rated securities is unnecessary, and it will potentially create confusion and inconsistency in our guidance. The SVO does not recommend including that suggested change. There was also a request for a new appeal process specific to private rating securities. The existing instructions in the P&P Manual already provide for an insurer to request clarifications from an SVO analyst, appeal an SVO opinion, and escalate to the Task Force chair. Given the robust existing instructions to address this issue, the SVO believes there is no reason to create an alternate process. Likewise, the only entities that should be permitted to appeal an SVO opinion are insurers, as NAIC designations are only intended for NAIC members and are not for the issuers of securities. This recommendation had an option for issuers of securities to also appeal SVO decisions, which is not consistent with the rest of the P&P Manual. The SVO recommends that the suggested changes in green not be adopted by the Task Force.

Michael Reis (Northwestern Mutual Life Insurance Company) said he was unable to follow all of what Mr. Therriault said, but he understood that he did not recommend the changes in green. Mr. Reis said industry was not looking for a new appeals process, but they would like to know why a security is being rejected. If it is being rejected because it is not FE per the P&P Manual or because NAIC staff does not believe it is a bond for the Statement of Statutory Accounting Principles (SSAP) No. 26R—Bonds or SSAP No. 43R—Loan-Backed and Structured Securities, industry is asking that they be told why a security is rejected.

Mr. Therriault said there are extensive instructions in Part One of the P&P Manual, so if any insurer has a question about a filing, they can ask and the SVO analyst will respond. He encouraged companies to take advantage of that process if there is a question about anything the SVO is doing.

Mr. Reis said if a security is rejected, there should automatically be a disclosure without having to request that information. Mr. Therriault said if there is a concern about our opinion, a filer can submit a quick email to the SVO analyst. Requiring a formal detailed response on every filing would create an extra burden on SVO staff. Linda Phelps (NAIC) said the analysts include a very brief rejection reason, and if anybody wants additional information beyond that, they should reach out to the analyst.
Mr. Reis suggested that the topic be taken offline because there are a number of companies requesting this update, and he would like the opportunity to discuss it further. Tracey Lindsey (NASVA) said filers are looking for transparency. If someone else files a security, it gets rejected for the rest of the holders who do not know what the reason is for the rejection. This could be a dropdown option in VISION to indicate why something was not accepted by the NAIC. Mr. Therriault said it might be worth taking this offline because it does not sound like the procedure in the amendment or an appeal process but more of an enhancement to the VISION system.

Sasha Kamper (PPIA) said Mr. Therriault recommended that the ratings rationale be an ongoing filing requirement as opposed to a one-time filing requirement. The reason industry asked for the one-time requirement is because the output received from the rating agencies is very deal dependent, even by the same rating agency. Some deals may have ongoing rationales that are updated annually. Others may have an in-depth rationale report that is done at time of issue; thereafter, they only get a private rating letter. An update to the rating letter and any comments related to the why might be somewhat cursory from the rating agency and particularly for those deals, especially again issued before 2022. The work product that the borrower gets is a result of a commercial negotiation and a legal agreement between the rating agency and the borrower. Industry may have difficulty getting those borrowers that only paid for a one-time rationale to go back and amend their agreements with the rating agencies to produce rationales every year. If you have the rationale that describes the deal in full, then you can at least understand the nature of the deal and what the rating agency was looking at when they first rated it, then you get updates and the ratings thereafter. Unless there has been a major amendment or structural change to the transaction, that should at least provide the analysts at the NAIC with enough clarity to understand the deal. Industry would not have any problem with the extent that rationales are available. It is really an issue of the fact that sometimes it will not be available and all that was receives was the letter.

Mr. Fry said that can be discussed a little bit more before Mr. Therriault puts out his final version, and if we have two versions to consider, the Task Force can decide on its next call.

Mr. Reis said there is broad agreement for the proposal and moving forward with it. Industry had a call with Mr. Therriault and narrowed the gap to around the edges for some items. Some of the rating agencies have reached out to us and expressed their confusion as to what should be included in our meeting rationale report; they could be 500 pages or five sentences. One thought that they could use the rating rationale that the SVO provides in the Regulatory Treatment Analysis Service (RTAS) Letter, but that probably does not have the level of data that Mr. Therriault is looking for. Industry stands ready to work to make that process as efficient and beneficial as possible.

Ms. Mears said the question for Ms. Camper, just as a follow up to her comments, especially when you are talking about the potential that some of those updates may not include the rationale, is whether that is the main concern or whether it is feasible that some of these private letters are not updated, there is only the initial rating provided and then nothing subsequent to that. Ms. Kamper said it is not clear whether the rationales are updated or not. The rules in the P&P Manual make it very clear that for a private ratings letter to be valid and for security to be FE, it has to be reviewed no less than annually. If there is no updated ratings letter to prove that it was at least reviewed, then it cannot be FE and would need to be filed.

Mr. Fry advised that anyone who has any concerns around these issues reach out to Mr. Therriault. Mr. Therriault will rework a new version and expose it.

3. Received a Referral from the Statutory Accounting Principles (E) Working Group on Non-Conforming CTLs

Mr. Fry said the next item on the agenda is informational for now. The Task Force has received a referral from the Statutory Accounting Principles (E) Working Group about credit tenant loan (CTL) investments and more specifically about the residual risk threshold. SVO staff are going to put together a memorandum that will address whether, in their opinion, it is appropriate to revisit the 5% residual risk threshold that we are currently operating under for CTLs. Then if applicable, the memorandum will address what would be an appropriate residual risk threshold, if there is one. The Task Force will also be considering whether other mechanisms or compensating controls could be incorporated as a mitigating factor. SVO staff will be putting together this response, and they will let the Task Force look at that response.

Mr. Everett stated that he is a little confused looking at the memorandum where it says that we are looking at these like their mortgage loans; they are basically securities. If it were a mortgage loan, then the lender would end up with the property at the end of the day; that does not happen here. Mr. Everett asked what the considerations are, because generally when looking at tenant credit quality, the lease obligation, the structure of the transaction, and real estate considerations really come in only when the property goes dark. He also asked what the broader picture is here.
Mr. Therriault said the purpose of the CTL structure, which evolved sometime in the 90s, is that the credit risk should be to a corporate obligor. Some of these transactions have a residual risk, which means the bond continues beyond the lease term so there is a residual threshold, which then has exposure to the property without a lease payment associated with it. When that original decision was made to permit these on Schedule D reporting, that was a requirement both in the P&P Manual and the Accounting Practices & Procedures Manual (AP&P Manual) for guidance to be allowed and recorded on Schedule D. This is a long-standing instruction that the Statutory Accounting Principles (E) Working Group is looking at as part of its project to consider whether the classification of this asset should still be allowed to be reported as a Schedule D bond. The referral is a question coming from the Working Group to SVO staff that reviews these transactions asking if, in its opinion, this threshold is still appropriate and whether there might be anything out there to prevent that kind of residual exposure underlying the asset.

Mr. Everett asked if the Statutory Accounting Principles (E) Working Group is setting the investment standards. Mr. Therriault said the Working Group sets the classification of assets and what schedules they are reported on. The Task Force sets the risk assessment of those assets. Mr. Everett said it looks like there is a shift from the P&P Manual of the residual risk to the AP&P Manual. Mr. Therriault said this referral is to guidance that is in the P&P Manual now that says there cannot be more than a 5% residual risk for a CTL to be conforming to the P&P Manual. SVO staff are aware that there are CTLs that are not conforming.

John Garrison (Lease-Backed Securities Working Group) said the Working Group welcomes the referral from the Statutory Accounting Principles (E) Working Group to this Task Force to reconsider the appropriate residual percentages for CTLs; it is a reconsideration that is long overdue. The 5% current threshold that is in the P&P Manual was put in place 27 years ago when CTLs were first introduced. It was originally intended by all parties to be a sort of provisional number that would be reconsidered in several years, as more information on the performance of these securities became available. The number has not changed over the 27 years since it was first introduced, even as the markets continued to evolve and the strong performance of these securities was well documented. Repeated studies have shown that CTLs have the best performance of any insurance company investment asset. As the Task Force considers this referral, there are a couple of factors to consider. First, under the code of federal regulations, a 50% residual balance is the percentage that is already set forth as the allowable standard by the U.S. Securities and Exchange Commission (SEC) for asset-backed and lease-backed securities. This regulation specifically states that securities backed by leases, and that is clearly the case with CTLs, may rely on up to 50% “on the cash proceeds from the disposition of the physical property underlying such leases.” Second, in other asset classes, a residual balance of 50% is generally consistent with an asset quality of AA. Third, the 50% standard that is set forth in the federal regulations is an across-the-board standard, and it includes many leased assets which are depreciating: equipment, rail, cars, airplanes, etc. Leased automobiles are subject to a higher standard, which is 65% for residual. Real estate is widely accepted to be a non-depreciating asset, so it seems nonsensical to us to submit it to a lower standard than it is currently allowed for other lease depreciating assets. Especially in the light of this 50% federal rule, a 5% threshold seems unreasonable and unnecessarily restrictive for insurance companies.

Mr. Garrison continued that, a change, as the Task Force considers this, from the 5% threshold to a standard of 50%, which we recommend, could be accomplished with a simple revision to the P&P Manual. It would resolve once and for all the whole issue of nonconforming CTL deals that were historically filed with rating letters from CRPs, all CTLs would be filed with the SVO, as they currently are. The CTLs are under the manual for an SVO-determined designation, which would create total transparency for the state insurance regulators. Second, it would bring outdated regulations in line with current industry practice. The referenced studies by the American Academy of Actuaries (Academy) document that CTLs are the best performing of any insurance company investment. So far, no evidence has been provided, and our Lease-Backed Securities Working Group is not aware of any deals with larger residual percentages that were submitted with filing letters; and FE have not performed any worse than CTLs with the 5% threshold or resulted in any significant losses, credit issues, or solvency issues for insurance company investors. A revision such as this would unfreeze these markets. Mr. Garrison said he has heard from many insurance company investors who have shied away from this market and have stated they are reluctantly accepting lower yielding investments rather than dealing with the cloud that is hanging over this market due to the regulatory uncertainty.

Mr. Fry said one interesting feature is the transparency part of that effort. If the threshold was raised these securities would require an SVO designation and would not be eligible for FE. The Task Force would have better control over the policy of these securities than it would with private letter ratings.
4. Received a Proposed Amendment to the P&P Manual to Update the List of NAIC CRPs to Reflect NRSRO Changes

Mr. Fry said agenda item four is to receive a proposed amendment to update the list of any CRPs to reflect recent NRSRO changes. The CRPs, Morningstar, and Dominion Bond Rating Service (DBRS) merged in 2019 to become a single NRSRO. Mr. Fry asked Mr. Therriault to provide an overview of the amendment.

Mr. Therriault said the catalyst for this amendment was the merger of Morningstar and DBRS. Because of that merger, there is now a single set of rating agency symbols. The P&P Manual currently has symbols for both Morningstar and DBRS. With the alignment under the DBRS symbol set, the proposal removes the Morningstar symbol set. In the process of going through the SEC’s Office of Credit Ratings (OCR) website, several other minor name changes were identified. It made sense to make all these updates to the P&P Manual to reflect these minor changes. There is a minor inconsistency on the OCR website related to the Kroll Bond Rating Agency (KBRA). It is referred to as the “Kroll Bond Rating Agency Inc.” but its Form NRSRO has “Kroll Bond Rating Agency LLC”; the LLC is the correct title. With the Task Force’s permission, the amendment would be modified for that correction. This is a non-substantive amendment to make some corrections and updates to this section of the P&P Manual.

Mr. Fry directed SVO staff to expose this amendment to update the list of NAIC CRPs to reflect NRSRO changes for a 30-day public comment period.

5. Discussed SEC Rule 18f-4 Under the Investment Company Act of 1940 Related to the Use of Derivatives by Registered Investment Companies

Mr. Fry said there is an update on the regulation of derivatives used by funds. When the Task Force met last July, Marc Perlman (NAIC) provided an update on the SEC’s proposed Rule 18f-4. Last October, the SEC adopted the final rule, a new framework for derivatives used by registered funds. Mr. Fry asked Mr. Perlman to provide an update to the Task Force on the new rule, specifically the parts that the SVO thinks might be pertinent to potential updates to the P&P Manual.

Mr. Perlman said the SEC adopted a final version of Rule 18f-4 in October 2020. The rule will allow funds to enter into derivative transactions, notwithstanding the Investment Company Act of 1940’s restrictions on derivatives, so long as funds meet certain conditions. Much of the final rule is substantially the same as the proposed rule described in July 2020. Funds will need to institute a derivatives risk management program, which would include stress testing, back testing and internal reporting. Funds would need to abide by a limit on fund leverage risk by instituting an outer limit on leverage, which would be based on a value at risk (VaR) calculation. Fund boards will need to approve of a derivative risk manager who will oversee the derivatives risk management program and report to the board. The SVO is focusing most closely on the exception to these requirements for limited users of derivatives, meaning funds that limit their derivative exposure to 10% or less of net assets. The final limited user exception differs from that in the proposal, and for the purposes of calculating the 10% exposure, funds can exclude certain derivative use to hedge currency and interest rate risks.

Pursuant to the P&P Manual, the SVO is required to determine if a fund is fixed income-like, meaning the SVO must determine whether a fund will generate predictable and periodic cash flows in a manner broadly similar to a situation where the holding of bonds or preferred stock of unknown credit quality were held individually. Under this test, the SVO is by extension granted discretion when determining whether funds’ use of derivatives is consistent with a fixed income-like security and is therefore eligible for an NAIC designation. The SVO recognizes that this discretion regarding the use of derivatives by funds can lead to a possible lack of predictability when a fund is submitted to us for potential inclusion on one of the SVO fund lists; therefore, the Task Force may want to consider a possible amendment to the P&P Manual to create a more predictable bright line test. One possible solution for the Task Force to consider would be to use Rule 18f-4 as a kind of guidepost for updated P&P Manual guidance on the use of derivatives by funds by adapting the rules and limited user standards to guide the SVO determination of what is an acceptable use of derivatives by a fund so that the fund payments can be considered fixed income.

For example, a more definitive limitation on the use of derivatives in funds consistent with the limited user exception and the rule could be established whereby the gross notional amount of derivatives cannot exceed 10% of the net asset value of the fund except for currency and interest rate swaps matched to securities in the fund portfolios and reverse repurchase agreements. The SVO believes that such a change would benefit the market by providing greater clarity to fund sponsors and investors while maintaining the limit on the use of leverage by funds. Additionally, the SVO recognizes that based on a 10% test, certain funds may not qualify as fixed income-like and would not be eligible for reporting as bonds on Schedule D, Part One. If the Task Force members believe there is interest by the Capital Adequacy (E) Task Force and RBC working groups, a separate risk assessment process for funds can be proposed, which would not qualify as fixed income-like, but it could be permitted to
receive NAIC designations, or modified version thereof, for reporting as common stock and Schedule D, Part 2 Section 2 but with an NAIC designation adjusted to reflect market risk in addition to credit risk, and a separate RBC factor might be necessary for such funds.

Mr. Fry said the SVO will soon produce some sort of an amendment that will be exposed through the Task Force’s normal process. If anyone has any ideas during this drafting phase, their comments will be taken into consideration.

Mr. Fry directed the SVO to prepare a P&P Manual amendment on the use of derivatives by funds for the Task Force to consider.

6. Discussed Other Matters

Mr. Fry said the Task Force is scheduling a call for the Spring National Meeting on March 22, 2021. A number of these items will be discussed on that call.

Mr. Kolchinsky said the NAIC has a policy of periodically re-submitting the vendor contracts. In 2015, the NAIC signed Blackrock to a three-year plus two one-year extension contract that was set to run out in 2020. Given the COVID-19 pandemic, this was pushed out one year, but now the Executive (EX) Committee of the NAIC has asked this request for proposal (RFP) as our usual business practice. The press release for the RFP was just released during this meeting, and it can be found on the front page of the NAIC website for anyone who is interested or curious to see.

Mr. Monahan asked if there is enough time to work through the comments assuming that the comment deadline is March 15, and the Spring National Meeting is the week of March 22. Mr. Kolchinsky said yes, and if there are any technical things, information should keep flowing. While we typically publish two weeks before a meeting, Mr. Therriault asked if the Task Force is fine with some of the materials being posted after that deadline. No concerns were expressed by the Task Force members.

Having no further business, the Valuation of Securities (E) Task Force adjourned.
1. Exposed an Updated Amendment to the P&P Manual to Include Instructions for the Financially Modeled RMBS/CMBS Securities to Map NAIC Designations Categories

Mr. Fry said there are two issues to address for the financially modeled NAIC designation for year-end 2020. He said the issues were not the fault of NAIC staff and were largely attributable to the use of price breakpoints. Sometimes there are shortcomings in that approach, and it produces results that do not seem logical. If a security is financially modeled and shows no losses in any of the modeling scenarios that the Securities Valuation Office runs and under the filing exempt (FE) process, it would be an NAIC 1 designation. If it had both of those characteristics, the security is automatically considered an NAIC 1 and does not need to go through the price breakpoint process. In May 2019, because the NAIC is moving towards 20 NAIC designations, at least for informational purposes, the Task Force had to map to the NAIC designations categories. These financially modeled no loss securities were originally going to be mapped to a NAIC 1.D for this year-end but ended up instead being mapping to an NAIC 1.A. As companies got ready to apply the new process, they realized that you would need to be both a zero loss security and be rated “AAA” and, if not, the security would need to go through the breakpoints. This was not the intent of the mapping change, and even though it has been exposed for some time, it should be fixed. There is updated language that would fix this unintended consequence and clarify that if an insurer has a financially modeled zero loss security that would also be an NAIC 1 under FE, it would now be mapped to an NAIC 1.D—the middle of the NAIC 1 scale. The Task Force could expose this for a very short time, maybe three days. If positive comments are received, then the Task Force could conduct an e-vote on the amendment to adopt it before year-end.

Mike Monahan (American Council of Life Insurers—ACLI) said the ACLI supports the expedited time frame and appreciates the Task Force’s and NAIC staff’s efforts to fix this issue. He said if the blame lies anywhere, it is on the mechanics of the price break points. He said the ACLI will be fully committed to working with NAIC staff and state insurance regulators in 2021 to solve that problem.

Francisco Paez (MetLife) said the solution that the NAIC staff are proposing here really addresses the issue. It basically leaves things in the same place that they had been in the past and the way that zero loss securities have been treated from a risk-based capital (RBC) standpoint. From that perspective, it resolves what was going to be a potential issue where there would have been a significant drift in NAIC designations in securities that are otherwise some of the top-quality securities insurance companies own.

Tracey Lindsey (North American Securities Valuation Association—NASVA) asked if perhaps the Task Force, as it considers the mapping to NAIC 1.D, could permit the mapping to NAIC 1.A for just this year-end because that is how insurer systems have been built with the existing mapping instruction in place today. There would be no impact to RBC for this year-end. Mr. Fry said there should not be an RBC effect for this yearend; the 20 NAIC designation categories are just informational, and he said he does not see a problem with that request. Charles A. Therriault (NAIC) said he is sympathetic to insurers’ system concerns. There is a fairly broad rating distribution for no loss securities that goes from AAA into the non-investment grade ratings. The thinking behind the original recommendation was to try to find a midpoint to give the overall estimation of risk. Mr. Therriault said the NAIC 1.A mapping could be an option for insurers that cannot change their systems to accommodate the NAIC 1.D correction.
Mr. Fry said the Task Force will need to look at this whole process and the price breakpoints next year. He said that permitting insurers that cannot make the change in mapping from an NAIC 1.A to NAIC 1.D will be captured in the minutes as an instruction if it is not operationally possible to make this update. Ms. Mears said she supports the plan to keep it as NAIC 1.D in the exposure with the allowance in the minutes of an NAIC 1.A, to at least ensure that companies that are able to use the NAIC 1.D in their systems can do so. There was no objection from the Task Force members to this instruction for year-end 2020.

Mr. Fry directed SVO staff to expose the updated *Purpose and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) instructions for the financial modeled residential mortgage-backed securities (RMBS)/commercial mortgage-backed securities (CMBS) mapping to NAIC designations categories for a three-day public comment period ending Dec. 22, 2020. He also directed SVO staff to conduct an e-vote immediately after the exposure period ends and include in the minutes permitting insurers that cannot make the system change in mapping from an NAIC 1.A to NAIC 1.D to report the NAIC 1.A for 2020.


Mr. Fry said in 2019, there were around 3,900 no loss securities. For 2020, the modeling has 500–600 fewer no loss securities. This means that if the security is no longer no loss, it must now go through the price breakpoints. A lot of these securities trade based on the interest rate environment. Because the security is now no longer no loss, the security must use the price breakpoints which could take a security, for example, that has a very small loss in the most draconian of the five scenarios, to now be an NAIC 3, NAIC 4 or NAIC 5. It might be rated AA by the rating agencies, but the price breakpoints would turn it into a below investment grade. That is the problem with the rules as they are now.

Mr. Paez said there are two things happening. On the one hand, there is the modeling results that this year are more conservative than they had been in the past, and rightly so, given the economic environment. Combined with the low interest rate environment that has existed for some time now, the fixed rate and long duration nature of CMBS implies, from a pricing standpoint, that a lot of companies have been purchasing premium price CMBS securities that, up to last year, would have been a zero loss security. Because these securities had been zero loss, they did not need to go through the price breakpoints. But now, with the more conservative scenarios, that are appropriate given the market, those securities need to go through the price breakpoints because they no longer qualify as zero loss. Because they are owned at a significant premium, once put through the price breakpoints, there is a cliff effect that is very dramatic with securities that are otherwise very high-quality securities.

He said, to give a little bit of context, an analysis that was put out by Bank of America estimated that approximately half of securities that are AA-rated today that were zero loss last year are no longer a zero loss this year. Similarly, 75% of securities that were A-rated this year and were zero loss last year are no longer zero loss. That is a pretty substantial percentage of those two classes of CMBS securities that, when combined with premium pricing, is causing them to drift down significantly in terms NAIC designations. From the rating agency standpoint, the rating agencies are doing a fine job in terms of determining the risks. These continue to be some of the highest quality securities out there. From a pricing standpoint, the market generally perceives those securities as being of very high quality as well. From an NAIC designation standpoint, and by extension from an RBC standpoint, those securities are starting to drift down to NAIC 2, NAIC 3 and NAIC 4 under these new modeling results in 2020.

This is starting to cause some significant issues in the market. On the one hand, insurance companies looked at what that was going to mean in terms of impact to their RBC and started thinking that it may be preferable to sell those securities. There was a significant amount of activity a couple of weeks after the modeling interim results came out where insurance companies were the sellers of these types of securities. The buyers were other type of institutions, generally, that would not be subject to the same rules. Insurance companies were selling very high-quality securities that have a very attractive cash-flow profile for prudent asset-liability management, and they were getting picked up by other types of entities that were taking advantage of this opportunity. For that same reason, the appetite from insurance companies for these types of securities started to come down. The likely implication was that the number of potential providers of liquidity for those securities that continue to be owned by insurance companies, in many cases, was coming down and, therefore, had the potential of reducing the liquidity of these holdings. There was a real impact to the market. And again, the issue here is not really with the quality of these securities. These securities continue to be rated today in a very high rating category by the rating agencies. They continue from a pricing standpoint to be priced by the market as very high-quality securities. But from an NAIC designation perspective, they were going to suffer and have a potential meaningful impact on companies’ RBC.
Eric Kolchinsky (NAIC) said the breakpoint approach greatly penalizes fixed rate securities without any real reason. Using a real bond example from a spreadsheet from the midyear file or the interim file, it has a book adjusted carrying value (BACV) price of 102.7 but has an intrinsic price of 99.25. That is not a huge loss, at 75 basis points (bps), but it still would be in the range of NAIC 1 or NAIC 2 in terms of risk. However, it would be held at NAIC 3 because of the breakpoint analysis and only because of the BACV price of 102.7. That price reflects that interest rates have been steadily moving down, and these are fixed rate bonds. As interest rates move down and you get a wider coupon in the bond, the price goes up and has no aspect of quality. Unlike RMBS, where they are floaters, and if there is a credit issue, they will move down as a result of price. Here you had bond move up in price because of rates and nothing to do with credit. It is not a bad bond, but it would be held at NAIC 3 under the breakpoint analysis.

Mr. Kolchinsky said one of the things that was put in place was what is called the “no loss exception.” This was done around 2010 because of this very issue with CMBS bonds. Basically, an insurer could hold something at NAIC 1 under one of two conditions. First, there was no loss or zero losses in any of the scenarios that were run by the NAIC. Second, if it had gone through the NAIC FE rules, it would still be NAIC 1. This covers the first part of the discussion today, which is the change in the language.

Mr. Kolchinsky said he took a look at the effect of the new framework and about $8 billion of bonds for 2019 that have a rating between AA or A, and they have zero loss. In this case, one of the things that was discovered was that in the past, the flag sent in the Structured Securities Group (SSG) files only addressed the scenarios and did not take into account any ratings. These securities have zero loss in our scenarios, they have original ratings of AA or A, and they are held at a premium because that is what happens in a low rate environment. As rates go down, these bonds would be penalized. In the example bond, which is held by a number of insurers with BACV pricing from 101.1 to 101.6, there were no losses in any scenario, it had an original rating of AA, and it seems to be doing fine. However, it would still have to be held at NAIC 2, which makes no sense.

SSG staff recommend the Task Force accept the proposed editorial changes to the mapping framework and for 2021 look at getting rid of the price breakpoints. The ACLI proposal came in late, and SSG staff have been trying to figure out what can be done, as staff are sympathetic to the effects of the price breakpoints. The proposal from the ACLI would be very difficult to implement operationally. However, it is possible to lower the threshold as to where the flag for something to be considered zero loss is set. SSG staff propose lowering that threshold to 99.5, so that means it would take about 50 bps of discounted loss before it is flagged as having some losses. These are bonds that are still held as NAIC 1 and will still have capital held against them, just 40 bps for asset valuation reserve (AVR) companies and 60 bps for non-AVR companies. SSG staff thought that giving them some leeway in the allowance to be held at NAIC 1 through this framework makes sense. SSG staff provided a quick analysis of securities that were modeled in 2020 and 2019. For the ones that had no losses, the basis of their analysis in giving them some leeway in the allowance to be held at NAIC 1 through this framework makes sense. SSG staff provided a quick analysis of securities that were modeled in 2020 and 2019. For the ones that had no losses, the basis of their analysis in giving them some leeway in the allowance to be held at NAIC 1 through this framework makes sense.

This is the serial effect of the nonlinearities. If the nonlinearities that are built into the capital level already, as into this nonlinearity of the breakpoint approach and the nonlinearity of the no loss, when you line them up, you can have these really convex results. And that is what we are seeing here, and SSG staff do not think those results are the correct result. This would only be a temporary solution until further changes can be made next year, as Mr. Kolchinsky discussed, to get rid of the breakpoints.

Mr. Fry said the Task Force is exposing some language changes to fix one issue. With this issue, he said that SSG has the discretion to use these parameters and change them without the Task Force necessarily being required to approve them. Mr. Kolchinsky said that is correct, but he does not want to do it without letting the Task Force know. He said he wants to make sure that people understand what is being done and that there are no issues with the approach.

Mr. Fry said normally the SSG would have run the results, but it has held off to discuss this change and will be a few days late. Mr. Kolchinsky said they can make the change quickly and may only be a day or two late.

Mr. Monahan thanked Mr. Kolchinsky for the presentation, the quick response, the simplified solution to this issue for year-end, and fully engaging with state insurance regulators and NAIC staff in 2021 to develop a long-term solution.
Rakesh Kansara (New England Asset Management) said the last slide states that this is for year-end 2020 CMBS only. He asked if this applies also to the post-crisis fixed rate RMBS. Mr. Kolchinsky said they did not analyze RMBS and just focused on CMBS. He said that it would generally apply to post-crisis security, theoretically, but in terms of procedurally trying to find that with this time left might be difficult. Mr. Kansara agreed that the pre-financial crisis RMBS years were all floater and that it is a different deal, but just to draw some distinctions on the post-financial crises RMBS securities, they are fixed-rate securities. In most cases, but not all, because of their duration, they will trade at premium prices in the current low-rate environment. And it may have a similar impact on the NAIC designation change from last year to this year because of purely interest rates. Mr. Kolchinsky said he does not have an issue making this threshold change; the same thing applies for RMBS as well, but he asked if the Task Force members had a concern. Mr. Fry said the SSG can study it and see that it does the same and make the change without compromising the rest of the process. Ms. Mears agreed.

Having no further business, the Valuation of Securities (E) Task Force adjourned.
MEMORANDUM

TO:  Kevin Fry, Chair, Valuation of Securities (E) Task Force
     Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
       Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

CC:     Marc Perlman, Investment Counsel, NAIC Securities Valuation Office (SVO)

RE:     Proposed Amendment to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) to Update the Financial Modeling Instructions for RMBS/CMBS Securities and Direct IAO Staff to Produce NAIC Designation and NAIC Designations Categories for Non-Legacy Securities

DATE:  February 03, 2021

1. **Summary** – On Oct. 11, 2018, the Valuation of Securities (E) Task Force adopted an amendment to delete the Modified Filing Exempt (MFE) provisions from the P&P Manual and directed a referral to the Statutory Accounting Principles (E) Working Group recommending the deletion of the MFE provisions from Statement of Statutory Accounting Principles (SSAP) No. 43R—Loan-Backed and Structured Securities. The effect of these changes resulted in these securities coming under the filing exempt instructions in the P&P Manual, if they have an Eligible NAIC CRP Credit Rating assigned to them. This change eliminated using the book adjusted carrying value to determine the NAIC designation for these securities.

The IAO staff reported to the Task Force at the 2019 Summer National Meeting that at some point the NAIC should align the RMBS/CMBS modeling to provide a single NAIC Designation for modeled RMBS/CMBS. This would have been a change from the current practice of providing a series of book adjusted carrying value price breakpoints to companies to determine the NAIC designation. The IAO staff submitted a proposal to the Task Force at the 2019 Fall National Meeting to eliminate the book adjusted carrying value price breakpoint process but the Task Force decided at the Feb. 4, 2020 meeting to defer such a change because industry expressed concerns there would be significant adverse risk-based capital (RBC) consequences from making such a change at that time.

In March 2020, the impact from the pandemic was just beginning to become apparent in the U.S. The pandemic’s effect on RMBS and CMBS securities became more observable during the 2020 year-end financial modeling process. The 2020 year-end financial modeling identified several securities that no longer qualified as being zero-loss because more conservative scenarios, necessary to reflect the economic impact of the pandemic, were applied. Once these securities no longer qualified as being zero-loss, they became subject to the book adjusted carrying value price breakpoints process. Many of these securities are owned at a significant premium because of the low interest rate environment and, once the price breakpoints were applied, securities that would otherwise be considered very high...
quality were required to be reported as an NAIC 2, 3, or 4 just because of their book adjusted carrying value and not because of any credit concern.

At the Task Force’s Dec. 18, 2020 meeting, industry, represented by the ACLI, agreed with the IAO staff that the mechanics of the price break points was causing insurer owned securities with otherwise strong credit to be reported as NAIC 2, NAIC 3 and NAIC 4 under the financial modeling price breakpoints process purely because they are owned at a premium and not because of their credit risk. It was also discussed that the use of financial modeling price breakpoints process was possibly disrupting the market for these otherwise high-quality investments. SSG staff at that meeting recommended getting rid of the price breakpoints process.

2. Recommendation – The IAO staff recommends that the NAIC move to a single NAIC designation and NAIC designation category for all non-Legacy Securities (those financially modelled RMBS/CMBS securities that closed on or after to Jan. 1, 2013). Moving away from financial modeling price breakpoints process for these non-Legacy Securities will avoid further and future market disruptions and permit a clearer assessment of the credit risk assessment for these securities that will not be impacted by the insurers book adjusted carrying value. Making this change for only non-Legacy Securities preserves their historical treatment. Given the potential impact to SSAP 43R - Loan-Backed and Structured Securities, staff recommends a referral to the Statutory Accounting Principles (E) Working Group.

3. Proposed Amendment – The following text shows the revisions in Part Four that would appear in the 2020 P&P Manual format.
PART FOUR
THE NAIC STRUCTURED SECURITIES GROUP
DEFINITIONS

1. The following terms used in this Part Four have the meaning ascribed to them below.

- **ABS** stands for asset-backed securities and means structured securities backed by consumer obligations originated in the United States.

- **CMBS** stands for commercial mortgage-backed securities and means structured securities backed by commercial real estate mortgage loans originated in the United States. The definition of CMBS may refer to securitizations backed by commercial mortgages, respectively, originated outside of the United States if and to the extent that the vendor selected by the NAIC to conduct the financial modeling: (a) has the necessary information about the commercial mortgage and commercial mortgage loans originated outside of the United States to fully model the resulting securities; and (b) can adapt the modeling process to account for any structural peculiarities associated with the jurisdiction in which the mortgage was originated.

- **Initial Information** means the documentation required to be filed with an Initial Filing of an RMBS or a CMBS CUSIP, pursuant to the section below and pertaining to Loan Information, Reps and Warranty Information and Structure and Formation Information for the transaction, where:
  
  - **Loan Information** means a review of the loan files by a third party to assess the sufficiency of legal title and other related issues.
  
  - **Reps and Warranty Information** means the actual representation and warranties in effect for the securitization given by the mortgage originator(s) to the Trust pertaining to loan origination processes and standards, compliance with applicable law, loan documentation and the process governing put backs of defective mortgages back to the originator(s).
  
  - **Structure and Formation Information** means the waterfall, as described in the definition of Ongoing Information, information and documentation in the form of legal opinions and documentation governing the formation of the securitization and its entities relative to issues such as bankruptcy remoteness, true sale characterization, the legal standards and procedures governing the securitization and other similar issues.

- **Intrinsic Price** is an output of financial modeling, defined as ‘1 - weighted average of discounted principal loss’ expressed as a percentage, reflecting the credit risk of the security.
• **Legacy Security**, for the purposes of this section shall mean any RMBS and any CMBS that closed prior to January 1, 2013.

• **Official Price Grids** means and refers to those generated by the SSG and provided to an insurance company or insurance companies that own the security for regulatory reporting purposes.

• **Ongoing Information** consists of: (a) tranche level data; such as principal balance, factors, principal and interest due and paid, interest shortfalls, allocated realized losses, appraisal reductions and other similar information for the specific tranche; (b) trust level data, such as aggregate interest and principal and other payments received, balances and payments to non-tranche accounts, aggregate pool performance data and other similar information; (c) loan level performance information; and (d) a computerized model of rules that govern the order and priority of the distribution of cash from the collateral pool (i.e., the “waterfall”) to the holders of the certificates/securities—provided in the format and modeling package used by the NAIC financial modeling vendor.

• **Original Source**, with respect to a specific set of data, means the Trustee, Servicer or similar entity that is contractually obligated under the agreement governing the RMBS or CMBS to generate and maintain the relevant data and information in accordance with standards specified in applicable agreements or an authorized re-distributor of the same.

• **NAIC Designation Intrinsic Price Mapping** is the mapping of the Intrinsic Price to a single NAIC Designation and Designation Category employing the midpoints between each adjoining AVR RBC charges (pre-tax). The midpoints are directly used as the minimum Intrinsic Prices (weighted average loss points) for corresponding NAIC Designations and Designation Categories.

• **Price Grids** means and refers to CUSIP-specific price matrices containing six price breakpoints; i.e., each price corresponding to a specific NAIC Designation category. Each breakpoint on a Price Grid is the price point that tips the NAIC Designation for the RMBS CUSIP into the next NAIC Designation (credit quality/credit risk) category. The plural is used because two Price Grids are generated for any CUSIP. This reflects the difference in RBC for those insurance companies that maintain an asset valuation reserve and for those insurance companies that do not.
• **Re-REMIC** is a securitization backed by: (a) otherwise eligible RMBS from one or two transactions; or (b) otherwise eligible CMBS from one or two transactions at closing. Re-REMICs cannot acquire any Underlying Securities after closing.

• **RMBS** stands for residential mortgage-backed securities and means structured securities backed by non-agency residential mortgages originated in the United States, where the collateral consists of loans pertaining to non-multi-family homes. That includes prime, subprime and Alt-A mortgages, as well as home-equity loans, home-equity lines of credit and Re-REMICs of the above. Excluded from this definition is agency RMBS, where the mortgages are guaranteed by federal and federally sponsored agencies such as the Government National Mortgage Association (GNMA), Federal National Mortgage Association (FNMA) or Federal Home Loan Mortgage Corporation (FHLMC) and loans against manufactured or mobile homes or collateralized debt obligations backed by RMBS. The exclusion covers bonds issued and guaranteed by, or only guaranteed by, the respective agency. Also not included are loans guaranteed by the U.S. Department of Veteran Affairs or the U.S. Department of Agriculture’s Rural Development Housing and Community Facilities Programs. The definition of RMBS may refer to securitizations backed by residential mortgages, respectively, originated outside of the Unites States if and to the extent that the vendor selected by the NAIC to conduct the financial modeling: (a) has the necessary information about the residential mortgage and residential mortgage loans originated outside of the United States to fully model the resulting securities; and (b) can adapt the modeling process to account for any structural peculiarities associated with the jurisdiction in which the mortgage was originated.

• **Underlying Security** means the RMBS or CMBS backing a Re-REMIC. A Re-REMIC cannot be an Underlying Security.

**NOTE:** The definitions of RMBS and CMBS reflect limitations associated with the financial modeling process, NAIC credit rating provider (CRP) internal naming conventions and SSG processes, as more fully discussed below and may, therefore, be subject to a narrower or a broader reading in any reporting period. Please call the SSG with any concerns or questions about the scope of the definitions for a given reporting period. Also note:

• It is possible that the scope of the RMBS and CMBS definitions may be broadened because the financial modeling vendors indicate other collateral or waterfall structures can be modeled.
NAIC CRPs may adopt different internal conventions with respect to what market or asset segments are within their rated populations of RMBS, CMBS or ABS. This could affect the application of the adopted NAIC methodology or require the NAIC to select which naming process it wishes to adopt.

It is possible that the SSG will acquire analytical assessment capabilities that permit the assessment of existing, additional or different structured securities that cannot now be modeled or that are not currently rated.
ADMINISTRATIVE AND OPERATIONAL MATTERS

Certain Administrative Symbols

2. The following administrative symbols are used in the Valuation of Securities (VOS) Products to identify RMBS and CMBS that the NAIC vendor has confirmed will be subject to the financial modeling methodology described in this Part.

- **FMR** – Indicates that the specific CUSIP identifies a Legacy Security RMBS that is subject to the financial modeling methodology and the application of Price Grids to determine a NAIC Designation and Designation Category.

- **FMC** – Indicates that the specific CUSIP identifies a Legacy Security CMBS that is subject to the financial modeling methodology and the application of Price Grids to determine a NAIC Designation and Designation Category.

- **FSR** – Indicates that the specific CUSIP identifies a non-Legacy Security RMBS that is subject to the financial modeling methodology and assignment of a NAIC Designation and Designation Category by the SSG.

- **FSC** – Indicates that the specific CUSIP identifies a non-Legacy Security CMBS that is subject to the financial modeling methodology and assignment of a NAIC Designation and Designation Category by the SSG.

**NOTE:** The administrative symbols **FMR**, **FMC**, **FSR** and **FSC** are related to symbols that insurers are required to use in the financial statement reporting process. Under applicable financial statement reporting rules, an insurer uses the symbol **FM** as a suffix to identify Legacy Security modeled RMBS and CMBS CUSIPs and **FS** as a suffix to identify non-Legacy Security modeled RMBS and CMBS CUSIPs. The symbol **FM** or **FS** is inserted by the insurer in the financial statement as a suffix following the NAIC Designation Category; e.g., **2.B FM**, **3.C FS**.

The use of these administrative symbols in the VOS Product means the insurer should not use the filing exempt process for the security so identified.
Quarterly Reporting of RMBS and CMBS

3. To determine the NAIC Designation to be used for quarterly financial statement reporting for an RMBS or CMBS purchased subsequent to the annual surveillance described in this Part, the insurer uses the prior year-end modeling data for that CUSIP (which can be obtained from the NAIC) and follows the instructions in contained under the heading “Use of Net Present Value and Carrying Value for Financially Modelled Legacy Security RMBS and CMBS” below or follows the instructions in “Publication of Final Results Use of Intrinsic Price for Financially Modeled non-Legacy Security RMBS and CMBS” below, subject to, and in accordance with, SSAP No. 43R—Loan-Backed and Structured Securities.
FILING EXEMPTIONS

Limited Filing Exemption for RMBS and CMBS

4. **RMBS and CMBS that Can be Financially Modeled** – RMBS and CMBS that can be financially modeled are exempt from filing with the SVO. NAIC Designations for RMBS and CMBS that can be financially modeled are determined by application of the methodology discussed in this Part, not by the use of credit ratings of CRPs.

5. **RMBS and CMBS securities that Cannot be Financially Modeled**
   - **But Are Rated by a CRP** – RMBS and CMBS that cannot be financially modeled but that are rated by a CRP are exempt from filing with the SSG. The NAIC Designations for these RMBS and CMBS are determined by application of the filing exemption procedures discussed in this Manual.
   - **But Are Not Rated by a CRP** – RMBS and CMBS that cannot be financially modeled and that are not rated by a CRP are not filing exempt and must be filed with the SSG or follow the procedures, as discussed below in this Part.

Filing Exemption for ABS

6. ABS rated by a CRP are exempt from filing with the SSG.

Review of Decisions of the SSG

7. Analytical decisions made through the application of financial modeling are not subject to the appeal process. In the absence of an appeal, the SSG shall provide whatever clarification as to the results of financial modeling is possible to any insurer who requests it and owns the security, provided that it is not unduly burdensome for the SSG to do so. Any decision made by the SSG that results in the assignment of an NAIC Designation and does not involve financial modeling methodology, whether developed by the SSG on its own or in collaboration with the SVO, is subject to the appeal process.
REQUIRED DATA AND DOCUMENTS FOR TRANSACTIONS SUBMITTED TO THE SSG

8. The policy statement set forth in this section shall be applicable generally to any transaction filed with the SSG for an analytical assessment, including, but not limited to, a Price Grid or for assignment of an NAIC Designation. Any filing with the SSG is deemed to be incomplete unless the insurer has provided the information, documentation, and data in quantity and quality sufficient to permit the SSG to conduct an analysis of the creditworthiness of the issuer and the terms of the security to determine the requested analytical value. It is the obligation of the reporting insurance company to provide the SSG with all necessary information. It is the responsibility of the SSG to determine whether the information provided is sufficient and reliable for its purposes and to communicate informational deficiencies to the reporting insurance company.

Documentation Standards

9. In order for an insurer-owned RMBS or CMBS to be eligible for the year-end modeling process, conducted pursuant to this section below, the analysis must be based on information, documentation and data of the utmost integrity. A Legacy Security must meet the Ongoing Information requirements. An RMBS, CMBS or Re-REMIC that is not a Legacy Security must meet the Initial Information and Ongoing Information requirements. For the purposes of determining a Re-REMIC’s status as a Legacy Security, the closing date of the Re-REMIC (not the Underlying Security) shall be used. The SSG may, in its sole discretion, determine that the Initial Information and/or Ongoing Information is not sufficient and/or not reliable to permit the RMBS or CMBS CUSIP to be eligible for financial modeling. If the SSG determines that the Initial Information and/or Ongoing Information is not sufficient and/or not reliable to permit the RMBS or CMBS CUSIP to be eligible for financial modeling, it will communicate this decision to the insurer and invite a dialogue to ascertain whether alternative information is available that would be deemed sufficient and/or reliable by the SSG.

Initial Information Requirements

10. An RMBS or CMBS meets the Initial Information Requirements if the security meets one of the following three conditions:

- **RTAS** – The RMBS or CMBS was assigned a preliminary price grid or designation as described in this Part;

- **Initial Sufficiency Filing** – The RMBS or CMBS was reviewed by SSG through an Initial Sufficiency Filing; or
Safe Harbor – The RMBS or CMBS meets the Safe Harbor requirements.

Initial Sufficiency Information Filing

11. An insurance company may file Initial Sufficiency Information with the SSG for the purpose of obtaining a determination that an RMBS or CMBS CUSIP is eligible for financial modeling under the annual surveillance process discussed below. Initial Sufficiency Information is only filed once for any given RMBS or CMBS. Reporting insurance companies are solely responsible for providing the SSG with Initial Information. A determination by the SSG that a given RMBS or CMBS CUSIP is eligible for financial modeling after an Initial Sufficiency Filing assessment is subject to the further and continuing obligation that the SSG obtain or the insurer provide the SSG with updated Ongoing Information close to the date of the annual surveillance.

12. **Required Documents for Initial Sufficiency Filing** – An insurer that owns an RMBS or a CMBS for which Initial Information is not publicly available shall provide the SSG with the following documentation.

13. **RMBS** – Unless otherwise specified by the SSG in a Modeling Alert, as further described below, an Initial Filing for an RMBS consists of submission of Initial Information and Ongoing Information in the form of the following documentation:

   - Pooling and Servicing Agreement or similar
   - Prospectus, Offering Memorandum or similar; Accountant’s comfort letter
   - If applicable, ISDA Schedules and Confirmations or similar
   - Legal opinions given in connection with the transaction
   - Any other documents referenced by the above
   - Third-Party Due diligence scope document and raw results. If less than 100% due diligence, detailed description of the loan selection process
   - If applicable, loan purchase agreements or similar. Loan Tape

14. **CMBS** – Unless otherwise specified by the SSG in a Modeling Alert, as further described below, an Initial Filing for a CMBS consists of submission of Initial Information and Ongoing Information in the form of the following documentation:

   - Pooling and Servicing Agreement or similar
   - Prospectus, Offering Memorandum or similar; Accountant’s comfort letter
   - If applicable, ISDA Schedules and Confirmations or similar
Legal opinion given in connection with the transaction
Any other documents referenced in the above
Asset Summaries
Loan Tape
Loan documents, including reliable information about the terms of the transaction; including, but not limited to, financial covenants, events of default, legal remedies and other information about financial, contractual or legal aspects of the transaction in form and substance consistent with industry best practices for CMBS issuance.
In certain cases, additional documents below will enable the SSG to verify and validate initial underwriting information of the property securing the CMBS. These documents may be required in form and substance consistent with best practices for typical CMBS issuance.
Historical operating statements and borrower’s budget
Underwriter’s analysis of stabilized cash flow with footnotes of assumptions used
Property type specific, rent roll information
Appraisals and other data from recognized industry market sources
Independent engineering report (Property Condition Assessment)
Environmental Site Assessment (ESA) – Phase I/Phase II
Documentation related to seismic, flood and windstorm risks
Franchise agreements and ground leases, if applicable
Management agreements

SSG Modeling Alerts
15. The SSG shall at all times have discretion to determine that differences in the structure, governing law, waterfall structure or any other aspect of a securitization or a class of securitization requires that insurance companies provide Initial Information and/or Ongoing Information additional to or different from that identified in this Part. The SSG shall communicate such additional or different documentation requirements to insurers by publishing a Modeling Alert on the NAIC website and scheduling a meeting of the VOS/TF to ensure public dissemination of the decision.
Safe Harbor

16. Safe Harbor options serve as proxies for the Initial Sufficiency filing. The options reflect publicly available information that a third party has analyzed the Initial Information. Because the structured securities market is quite dynamic, the list of Safe Harbor options may change frequently, with notice and opportunity for comment, as described in this section. An RMBS or CMBS meets the Initial Information requirement if:

- At least two Section 17(g)-7 reports issued by different CRPs are publicly available;
- A security that is publicly registered under the federal Securities Act of 1933.

Ongoing Information Requirements

17. An RMBS or CMBS meets the Ongoing Information Requirements if Ongoing Information is available to the SSG and the relevant third-party vendor from an Original Source. The SSG, in its sole discretion and in consultation with the relevant third-party vendor, may determine that the Ongoing Information is not sufficient or reliable to permit a given RMBS or CMBS CUSIP to be financially modeled. However, in making such a determination, the SSG shall take into account reasonable market practices and standards.

Special Rules for Certain Re-REMICs

18. Re-REMICs are generally simple restructurings of RMBS or CMBS. An Initial Sufficiency Filing for a Re-REMIC (a) which is not a Legacy Security itself but (b) where each Underlying Security is a Legacy Security shall not require submission of information regarding the Underlying Securities. In most cases, a prospectus for the Re-REMIC will be sufficient. If the SSG determines that additional information about the Re-REMIC structure or formation is required, it will communicate this decision to the insurer and invite a dialogue to ascertain whether additional information is available that would be deemed sufficient by the SSG.
ANALYTICAL ASSIGNMENTS

ANNUAL SURVEILLANCE OF RMBS AND CMBS – MODELED AND NON-MODELED SECURITIES

Scope

19. This section explains the financial modeling methodology applicable to all RMBS and CMBS (defined above) securitizations, and the book/adjusted carrying value methodology applicable to a modeled Legacy Security, the NAIC Designation Intrinsic Price Mapping applicable to a modeled non-Legacy Security, and non-modeled securities subject to SSAP No. 43R—Loan-Backed and Structured Securities. Please refer to SSAP No. 43R for a description of securities subject to its provisions. The VOS/TF does not formulate policy or administrative procedures for statutory accounting guidance. Reporting insurance companies are responsible for determining whether a security is subject to SSAP No. 43R and applying the appropriate guidance.

Important Limitation on the Definitions of RMBS and CMBS

20. The definitions of RMBS and CMBS above are intended solely to permit the SSG to communicate with financial modeling vendors, insurance company investors who own RMBS and CMBS subject to financial modeling and/or the book/adjusted carrying value methodology and their investment advisors to facilitate the performance by the SSG of the financial modeling methodology described below. The definitions contained in this section are not intended for use and should not be used as accounting or statutory statement reporting instructions or guidance.

NOTE: Please refer to SSAP No. 43R—Loan-Backed and Structured Securities for applicable accounting guidance and reporting instructions.

ANALYTICAL PROCEDURES APPLICABLE TO RMBS AND CMBS SECURITIZATIONS SUBJECT TO FINANCIAL MODELING METHODOLOGY

Filing Exemption Status of RMBS and CMBS

21. RMBS and CMBS are not eligible for the filing exemption because credit ratings of CRPs are no longer used to set risk-based capital (RBC) for RMBS or CMBS. However, RMBS and CMBS are not submitted to the SSG.
Use of Financial Modeling for Year-End Reporting for RMBS and CMBS

22. Beginning with year-end 2009 for RMBS and 2010 for CMBS, probability weighted net present values will be produced under NAIC staff supervision by an NAIC-selected vendor using its financial model with defined analytical inputs selected by the SSG. The vendor will provide the SSG with an Intrinsic Price and/or a range of net present values for each RMBS or CMBS corresponding to each NAIC Designation category. The NAIC Designation for a specific Legacy Security RMBS or CMBS is determined by the insurance company, based on book/adjusted carrying value ranges, and the NAIC Designation for a specific non-Legacy Security RMBS or CMBS is determined by the NAIC Designation Intrinsic Price Mapping by SSG.

**NOTE:** Please refer to SSAP No. 43R—Loan-Backed and Structured Securities for guidance on all accounting and related reporting issues.

Analytical Procedures for RMBS and CMBS

23. The SSG shall develop and implement all necessary processes to coordinate the engagement by the NAIC of a vendor who will perform loan-level analysis of insurer-owned RMBS and CMBS using the vendor’s proprietary models.

### RMBS AND CMBS SUBJECT TO FINANCIAL MODELING

Setting Microeconomic Assumptions and Stress Scenarios

24. Not later than September of each year, the SSG shall begin working with the vendor to identify the assumptions, stress scenarios and probabilities (hereafter model criteria) the SSG intends to use at year-end to run the vendor’s financial model.

The Financial Modeling Process

25. Information about the financial modeling process can be found at [www.naic.org/structured_securities/index_structured_securities.htm](http://www.naic.org/structured_securities/index_structured_securities.htm).
Use of Net Present Value and Carrying Value for Financially Modeled Legacy Security RMBS and CMBS

26. For each modeled Legacy Security RMBS and CMBS, the financial model determines the net present value at which the expected loss equals the midpoint between the RBC charges for each NAIC Designation; i.e., each price point, if exceeded, changes the NAIC Designation. Net present value is the net present value of principal losses, discounted using the security’s coupon rate (adjusted in case of original issue discount securities to book yield at original issue and in case of floating rate securities, discounted using LIBOR curve + Origination spread). Because of the difference in RBC charge, the deliverable is five values for each RMBS and CMBS security for companies required to maintain an asset valuation reserve (AVR) and five values for companies not required to maintain an AVR. This is illustrated in the chart below.

<table>
<thead>
<tr>
<th>RBC charge / NAIC designation (pre-tax)</th>
<th>P&amp;C</th>
<th>RBC</th>
<th>Midpoint</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.3%</td>
<td>0.65%</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1.0%</td>
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<td></td>
</tr>
<tr>
<td>3</td>
<td>2.0%</td>
<td>3.25%</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>4.5%</td>
<td>7.25%</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>10.0%</td>
<td>20.00%</td>
<td></td>
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<tr>
<td>6</td>
<td>30.0%</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Life</th>
<th>RBC</th>
<th>Midpoint</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.4%</td>
<td>0.85%</td>
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<tr>
<td>2</td>
<td>1.3%</td>
<td>2.95%</td>
</tr>
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<td>3</td>
<td>4.6%</td>
<td>7.30%</td>
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<td>4</td>
<td>10.0%</td>
<td>16.50%</td>
</tr>
<tr>
<td>5</td>
<td>23.0%</td>
<td>26.50%</td>
</tr>
<tr>
<td>6</td>
<td>30.0%</td>
<td></td>
</tr>
</tbody>
</table>
27. The NAIC Designation and NAIC Designation Category for a given modeled Legacy Security RMBS or CMBS CUSIP owned by a given insurance company depends on the insurer’s book/adjusted carrying value of each RMBS or CMBS, whether that carrying value, in accordance with SSAP No. 43R—Loan-Backed and Structured Securities, paragraphs 25 through 26a, is the amortized cost or fair value, and where the book/adjusted carrying value matches the price ranges provided in the model output for each NAIC Designation and the mapped NAIC Designation Category, reflected in the table below, to be used for reporting an NAIC Designation Category until new Risk Based Capital factors are adopted for each NAIC Designation Category and new prices ranges developed; except that an RMBS or CMBS tranche that has no expected loss under any of the selected modeling scenarios and that would be equivalent to an NAIC 1 Designation if the filing exempt process were used, would be assigned an NAIC 1 Designation and NAIC 1.D Designation Category regardless of the insurer’s book/adjusted carrying value.

**NOTE:** Please refer to the detailed instructions provided in SSAP No. 43R.

<table>
<thead>
<tr>
<th>NAIC Designation Determined by Modeled Price Ranges</th>
<th>Mapped NAIC Designation Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.D</td>
</tr>
<tr>
<td>2</td>
<td>2.B</td>
</tr>
<tr>
<td>3</td>
<td>3.B</td>
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<tr>
<td>4</td>
<td>4.B</td>
</tr>
<tr>
<td>5</td>
<td>5.B</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

Use of Intrinsic Price for Financially Modeled non-Legacy Security RMBS and CMBS

28. The NAIC Designation and NAIC Designation Category for a given modeled non-Legacy Security RMBS or CMBS CUSIP owned by a given insurance is assigned by SSG and **does not** depend on the insurer’s book/adjusted carrying value of each RMBS or CMBS. The NAIC Designation and Designation Category assigned will be determined by applying the Intrinsic Price to the NAIC Designation Intrinsic Price Mapping, as defined in this Part.
29. Securities subject to *SSAP No. 43R—Loan-Backed and Structured Securities* that cannot be modeled by the SSG and are not rated by an NAIC CRP or designated by the SVO are either: (a) assigned the NAIC administrative symbol ND (not designated), requiring subsequent filing with the SVO; or (b) assigned the NAIC Designation for Special Reporting Instruction [i.e., an NAIC 5GI, NAIC Designation Category **NAIC 5.B GI** or NAIC 6* (six-star)].
MORTGAGE REFERENCED SECURITIES

Definition

30. A Mortgage Referenced Security has the following characteristics: A Mortgage Referenced Security’s coupon and/or principal payments are linked, in whole or in part, to prices of, or payment streams from, real estate, index or indices related to real estate, or assets deriving their value from instruments related to real estate, including, but not limited to, mortgage loans.

Not Filing Exempt

31. A Mortgage Referenced Security is not eligible for filing exemption but is subject to the filing requirement.

NAIC Risk Assessment

32. In determining the NAIC Designation of a Mortgage Referenced Security, the SSG may use the financial modeling methodology discussed in this Part, adjusted (if and as necessary) to the specific reporting and accounting requirements applicable to Mortgage Referenced Securities.

Quarterly Reporting for Mortgage Reference Securities

33. To determine the NAIC Designation to be used for quarterly financial statement reporting for a Mortgage Reference Security purchased subsequent to the annual surveillance described in this Part, the insurer uses the prior year-end modeling data for that CUSIP (which can be obtained from the NAIC) until the annual surveillance data is published for the current year. For a Mortgage Reference Security that is not in the prior year-end modeling data for that CUSIP, the insurer may follow the instructions in Part Two of this manual for the assignment of the SVO Administrative Symbol “Z” provided the insurer owned security meets the criteria for a security that is in transition in reporting or filing status.

NOTE: Please refer to SSAP No. 26R and SSAP No. 43R for the definition of and guidance on Structured Notes and Mortgage Referenced Securities. Please also refer to Part Three of this Manual for guidance about the filing exempt status of Structured Notes.
GROUND LEASE FINANCING TRANSACTIONS

Definition

34. Ground Lease Financing (GLF) transactions are defined and explained in “Ground Lease Financing Transactions” in Part Three of this Manual.

SSG Role and Process

1. On occasion, the SVO may refer a GLF transaction to the SVO for financial modeling of the GLF space leases or business operation, as applicable, in accordance with the process set forth in “Ground Lease Financing Transactions” in Part Three of this Manual. Following an SVO referral the SSG and SVO will maintain open communication related to requests for additional data, analytical questions and analytical conclusions. Any GLF transaction NAIC Designation will be assigned by the SVO.
THE RTAS – EMERGING INVESTMENT VEHICLE

Purpose

2. Price grids and/or Designations and Designation Categories are generated for the exclusive use of insurance companies and the NAIC regulatory community. Insurance companies use official Price Grids and/or Designations and Designation Categories by following the instructions in SSAP No. 43R—Loan-Backed and Structured Securities to derive a final NAIC Designation for the RMBS or CMBS, which they use to derive the RBC applicable for the RMBS or CMBS.

NOTE: Please refer to SSAP No. 43R for a full explanation of the applicable procedure.

Extension of Authority

3. The Regulatory Treatment Assessment Service – Emerging Investment Vehicle procedure is extended to the SSG, and the SSG is authorized to determine probable regulatory treatment for RMBS and CMBS pursuant to this Part or for other securities, where, in the opinion of the SSG, financial modeling methodology would yield the necessary analytical insight to determine probable regulatory treatment or otherwise enable the SSG to make recommendations to the VOS/TF as to regulatory treatment for a security.

Interpretation

4. To facilitate this purpose, wherever in the Regulatory Treatment Assessment Service – Emerging Investment Vehicle procedure reference is made to the SVO, it shall be read to also refer to and apply to the SSG, adjusting for differences in the operational or methodological context. The Regulatory Treatment Assessment Service – Emerging Investment Vehicle procedure shall also be read as authority for collaboration between SVO and SSG staff functions so as to encompass RTAS assignments that require the use of SVO financial, corporate, municipal, legal, and structural analysis and related methodologies, as well as of financial modeling methodologies.
Translation of Preliminary into Official Price Grids and/or NAIC Designations and Designation Categories

5. Price Grids and/or Designations and Designation Categories (“PGD”) generated by the SSG pursuant to an RTAS are preliminary within the meaning of that term as used in the Regulatory Treatment Assessment Service – Emerging Investment Vehicle procedure and accordingly cannot be used for official NAIC regulatory purposes. Preliminary NAIC Designations are translated into official NAIC Designations by the SVO when an insurance company purchases and files the security and the SVO conducts an official assessment. However, this Manual does not require the filing of RMBS and CMBS subject to financial modeling methodology with the SSG. It is, therefore, necessary to specify a procedure for the translation of preliminary Price Grids and/or Designations and Designation Categories (“Preliminary PGD”) into official Price Grids PGD that can be used for NAIC regulatory purposes. Preliminary Price Grids PGDs generated by the SSG become an official Price Grid PGD within the meaning of this section when an insurance company has purchased the security for which the Price Grid PGD was generated and reported that security for quarterly reporting purposes using the SSG generated Price Grid PGD. A Price Grid PGD for a security reported by an insurance company for quarterly reporting is effective until the SSG conducts the next annual surveillance pursuant to this Part at which time the Price Grid PGDs generated by the SSG at year-end shall be the official Price Grid PGDs for that security.
MEMORANDUM

TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
    Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)

CC: Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)
    Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Proposed Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office
    (P&P Manual) to Update the List of NAIC CRPs

DATE: February 2, 2021

1. **Summary** – On July 2, 2019, Morningstar, Inc. completed its acquisition of DBRS. The merger was announced on May 29, 2019. DBRS Morningstar reported that they are now the fourth largest credit ratings agency and a market leader in Canada, the U.S. and Europe in multiple asset classes and rate more than 3,000 issuers and 60,000 securities worldwide. The merger resulted in the credit ratings symbols of the two previous entities being combined into a single set of symbols.

2. **Recommendation** – The SVO recommend adoption of this non-substantive amendment removing references to the legacy entities and instead referring to the new combined national recognized statistical ratings organization (NRSRO) entity, DBRS, Inc., doing business as “DBRS Morningstar Credit Ratings” or “DBRS Morningstar.” This proposed change updates the rating agency names on the List of NAIC Credit Rating Providers to match those on the U.S. Securities and Exchange’s Office of Credit Ratings list of Current NRSROs and the CRP Credit Rating Equivalents to NAIC Designations and NAIC Designation Categories.

3. **Proposed Amendment** – The text containing the updates to the List of NAIC CRPs is shown below, edits in red, as it would appear in the 2020 P&P Manual format.
PART THREE
SVO PROCEDURES AND METHODOLOGY FOR PRODUCTION
OF NAIC DESIGNATIONS
The CRPs that provide Credit Rating Services to the NAIC are:

- **Moody’s Investor’s Service, Inc.** for credit ratings issued to financial institutions, brokers, or dealers; insurance companies; corporate issuers; issuers of asset-backed securities and issuers of government securities, municipal securities, or securities issued by a foreign government.

- **S&P Global Ratings Standard and Poor’s**, for credit ratings issued to financial institutions, brokers, or dealers; insurance companies; corporate issuers; issuers of asset-backed securities and issuers of government securities, municipal securities, or securities issued by a foreign government.

- **Fitch Ratings, Inc.** – For credit ratings issued to financial institutions, brokers, or dealers; insurance companies; corporate issuers; issuers of asset-backed securities and issuers of government securities, municipal securities, or securities issued by a foreign government.

- **Dominion Bond Rating Service (DBRS)** – For credit ratings issued to financial institutions, brokers, or dealers; insurance companies; corporate issuers; issuers of asset-backed securities and issuers of government securities, municipal securities, or securities issued by a foreign government.

- **A.M. Best Rating Services, Inc. Company (A.M. Best)** – For credit ratings issued to insurance companies; corporate issuers and issuers of asset-backed securities.

- **Morningstar Credit Ratings, LLC** – For credit ratings issued to financial institutions, brokers, or dealers; corporate issuers and issuers of asset-backed securities.

- **DBRS, Inc. (DBRS Morningstar)** - For credit ratings issued to financial institutions, brokers, or dealers; insurance companies; corporate issuers; issuers of asset-backed securities and issuers of government securities, municipal securities, or securities issued by a foreign government.

- **Kroll Bond Rating Agency, LLC.** – For credit ratings issued to financial institutions, brokers, or dealers; insurance companies; corporate issuers; issuers of asset-backed securities and issuers of government securities, municipal securities, or securities issued by a foreign government.

- **Egan-Jones Ratings Company** – For credit ratings issued to financial institutions, brokers, or dealers; insurance companies and corporate issuers.

- **HR Ratings de Mexico, S.A. de C.V.** – For credit ratings issued to financial institutions, brokers, or dealers; corporate issuers and issuers of government securities, municipal securities, or securities issued by a foreign government.
Please note that the existence of a rating does not eliminate the requirement to file on SAR on any insurer-owned security not currently listed in this Manual unless exempted from filing.

**CRP Credit Rating Equivalent to NAIC Designations and NAIC Designation Categories**

Note: This is a listing of only the “generic” Credit Rating Provider (CRP) rating symbols. CRPs use a variety of symbols, including combinations of prefixes and suffixes that provide additional information about the rating symbol which are described in the CRP’s documentation. There are over 2,000+ unique rating symbols used by CRPs to describe long-term securities. The SVO maintains a master list of Credit Ratings Eligible for Translation to NAIC Designations. The SVO does not currently translate short-term security ratings as part of its Compilation and Publication of the SVO List of Investment Securities incorporated into the NAIC’s AVS+ product.
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FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

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Date: 4/19/21

Financial Regulation Standards and Accreditation (F) Committee
Virtual 2021 Spring National Meeting
April 12, 2021

The Financial Regulation Standards and Accreditation (F) Committee met April 12, 2021. The following Committee members participated: Elizabeth Kelleher Dwyer, Chair (RI); Lori K. Wing-Heier, Vice Chair (AK); Alan McClain (AR); Andrew N. Mais (CT); Colin M. Hayashida (HI); Sharon P. Clark (KY); Gary D. Anderson (MA); Eric A Cioppa (ME); Mike Causey represented by Jackie Obusek (NC); Bruce R. Range represented by Justin Schrader (NE); Larry D. Deiter (SD); Doug Slape (TX); Scott A. White (VA); and Jeff Rude (WY). Also participating were: Kathy Belfi (CT); John Rehagen (MO); and Dave Wolf (NJ).

1. **Adopted its 2020 Fall National Meeting Minutes**

Commissioner Clark made a motion, seconded by Director Wing-Heier, to adopt the Committee’s Dec. 7, 2020, minutes (see NAIC Proceedings – Fall 2020, Financial Regulation Standards and Accreditation (F) Committee). The motion passed unanimously.

Superintendent Dwyer said the Committee met April 8 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee voted to award continued accreditation to New Mexico and Tennessee.

2. **Adopted Revisions to the 2020 NAIC Publications Referenced in the Accreditation Standards**

Superintendent Dwyer said there are several NAIC publications currently included in the accreditation standards by reference. At each Spring National Meeting, the Committee is to review revisions made to these publications in the prior year. Each of the applicable groups that developed revisions to the publications in 2020 have provided the Committee with a memorandum discussing the revisions, and they indicated whether the revisions should be considered significant or insignificant for accreditation purposes. This included the following publications: the Accounting Practices and Procedures Manual (AP&P Manual) (Attachment One); the Annual and Quarterly Statement Blanks and Instructions (Attachment Two); the Financial Condition Examiners Handbook (Attachment Three); Risk-Based Capital (RBC) Formulas and Instructions for Life and Property/Casualty (P/C) Insurers (Attachment Four); the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) (Attachment Five); and the Valuation Manual (Attachment Six). The working group or task force responsible for each of these publications has deemed their 2020 changes as insignificant to the accreditation process.

Chief Deputy Commissioner Slape made a motion, seconded by Superintendent Cioppa, to adopt the revisions to each of the publications immediately by reference to the accreditation standards. The motion passed unanimously.

3. **Exposed Revisions to the Part A Preamble to Account for Inclusion of Model #787 as a New Accreditation Standard**

Superintendent Dwyer stated that at the 2019 Fall National Meeting, the Committee adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787), more commonly referred to as the XXX/AXXX Model Regulation, as a new accreditation standard. This decision was confirmed by the Executive (EX) Committee and Plenary at the 2020 Summer National Meeting. The model establishes uniform, national standards governing reserve financing arrangements pertaining to term life and universal life insurance policies with secondary guarantees. Model #787 also includes provisions to ensure that funds backing these captive reinsurance transactions, which consist of primary security and other security, are held in the forms and amounts that are appropriate. Model development was prompted by concerns regarding the security held under these transactions; and an interim solution, outlined by the XXX/AXXX Captive Reinsurance Framework, was included in the accreditation program through the Part A Preamble. The Part A Preamble must now be updated to reference Model #787 as the standard for applicable transactions. This change is not seen as a substantive change. It does not change the scope of the Preamble, but rather it is a straightforward update to reflect the codification in the form of Model #787. At this time, there are no proposed changes to applicability of captives reinsuring variable annuities (VA) or long-term care (LTC), but they will continue to be included within the Preamble with an effective date to be determined based upon regulatory needs.

Superintendent Cioppa stated that he wants to ensure that the references to captives reinsuring VA and LTC business are not forgotten. He suggested that the Financial Regulation Standards and Accreditation (F) Committee may consider referring the...
topic to the Financial Condition (E) Committee to get an update on the companies’ utilization of captives for VA and LTC. Superintendent Dwyer stated that an inquiry would be made to the Financial Condition (E) Committee.

Director Wing-Heier made a motion, seconded by Superintendent Cioppa, to expose revisions to the Part A Preamble to account for inclusion of Model #787 as a new accreditation standard for a 30-day public comment period (Attachment Seven). The motion passed unanimously.

4. Exposed the 2020 Revisions to Model #440 and Model #450 as an Update to the Accreditation Standards

Superintendent Dwyer stated that in December 2020, the NAIC adopted revisions to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). These revisions implement a group capital calculation (GCC) for the purpose of group solvency supervision and a liquidity stress test (LST) for macroprudential surveillance. The revisions are independent of each other and followed two separate workstreams when developed. However, they affect the same sections of the models; therefore, they benefit from joint consideration when discussing if and how to include each in the accreditation standards. In the materials, there are two separate referrals, one from each workstream, which have been combined under one referral from the Financial Condition (E) Committee.

Commissioner White summarized the March 8 referral from the Financial Condition (E) Committee (Attachment Eight). He stated that the GCC and LST were two of the NAIC’s top priorities before being adopted by the Financial Condition (E) Committee; therefore, adoption of them as an accreditation standard is appropriate. The recommendation is that the models be adopted as closely as possible with one exception related to subgroup reporting, as reflected in the proposed significant elements.

Commissioner White stated there are two issues the Financial Regulation Standards and Accreditation (F) Committee should be aware of, and the first relates to the recommended timing under which the GCC and LST should become standards. The referral recommends that the Committee waive its procedures and expeditiously adopt the GCC standards to ensure that the GCC is in place for those states that are a group wide supervisor of a U.S. group that has operations in the European Union (EU) or the United Kingdom (UK). He noted that this list of groups covers a broader spectrum than just internationally active insurance groups (IAIGs); it also includes any groups with operations in the EU or the UK. The reason for making this recommendation for expedited adoption is the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreements) that contemplate that such states should have the GCC in place for such groups prior to Nov. 7, 2022. The result of not meeting the deadline is the potential for U.S. insurers to be subject to Solvency II requirements. For groups not subject to the Covered Agreements, the referral recommends following the normal accreditation timeline for adoption. While the same urgency does not exist with these other states, the calculation itself is just as important as a tool for state insurance regulators assessing risk at the group level and enhancing policy owner protections.

Turning to the LST, Commissioner White stated that the Financial Stability (E) Task Force recommended a timing concurrent with the GCC, but it did not modify its suggestion of a Jan. 1, 2023, effective date for states not currently the lead state of a group subject to the LST. Their basis for this earlier effective date was not the Covered Agreements, but rather they believe timely adoption is important since the LST is intended to help the collective states ensure that a large liquidity event of the life industry could not materially disrupt the bond markets and thus cause federal regulators and members of the U.S. Congress (Congress) to question the oversight of state insurance regulators.

The LST currently only applies to 23 life insurance groups. However, it is common for legal entity insurers to move from one group to another, and that can affect the group dynamics, including the lead state determination. Therefore, it makes sense that each state has recorded the LST in their statutes to ensure that they will be prepared for any future appointments as the lead state.

Commissioner White stated that another key issue discussed in the development of the accreditation recommendation is the issue of confidentiality. Everyone agrees that the GCC and LST should be confidential, but there was some discussion about how specific the accreditation standard should be.

The American Council of Life Insurers (ACLI) strongly encouraged that more explicit language consistent with the models be included in the accreditation standard itself. However, the proposed language recommended for the accreditation standard
retains the more general language consistent with other accreditation standards that require a high standard of confidentiality. However, Commissioner White emphasized that the intent is for states to adopt legislation that has substantially the same force.

Superintendent Dwyer stated that as a reminder, the Accreditation Program Manual (Manual) sets forth a clear process and timeline when considering new or revised Part A standards. The first step in that process, upon receipt of a referral, is to expose the referral for a preliminary comment period of 30 days. After the initial comment period, if the Committee determines that it will proceed with considering the update to the standards, it will expose the standard for a one-year comment period, which would eventually result in an effective date, in this case, of Jan. 1, 2026. Alternatively, as Commissioner White noted, the referral from the Financial Condition (E) Committee includes a request to waive procedure, as allowed by the Manual, and expedite adoption for both the GCC and LST. Regardless of how the Financial Regulation Standards and Accreditation (F) Committee proceeds for accreditation purposes, both initiatives are important regulatory tools. For states with a group that has operations in the EU or UK, the Committee cannot emphasize enough the importance of implementing the GCC prior to Nov. 7, 2022, for those groups. Similarly, states with a life insurer affected by the LST requirements are encouraged to implement the model revisions and therefore the use of this important tool as soon as possible.

Chief Deputy Commissioner Slape stated that Texas has no issues with the LST; and while Texas does support the GCC, it does not agree with a broad application of the GCC to all U.S. insurance holding company systems. Texas favors a more limited application to just those groups that have international operations subject to the Covered Agreements. For years, the states have debated the merits of group capital.

Chief Deputy Commissioner Slape stated that the focus was on the window and wall approach, while solidifying our windows into groups by enhancing Form B, implementing group supervision and supervisory colleges, enhancing Schedule Y reporting, enhancing or editing holding company examinations, requiring the filing of an Enterprise Risk Report (Form F) and the Own Risk and Solvency Assessment (ORSA), and requiring corporate governance annual disclosures. These tools, if used correctly, already give state insurance regulators great insight into U.S. groups. Only after it was clear that the state's approach would not protect U.S. companies operating internationally from the imposition of international capital standards did state insurance regulators pivot to developing the GCC. Chief Deputy Commissioner Slape stated that the need for the GCC was cemented in the Cover Agreements and is the real reason for the GCC. Many states, if not most, have no groups with international operations.

Chief Deputy Commissioner Slape stated that some states will have challenges trying to get this model through their state legislature when the primary justification for group capital has no relevance to any groups in the state. He stated that this is bad public policy forced upon all states, our staffs, and all U.S. groups, and it is yet another regulatory burden. The working group that developed the GCC recognized the potential limits to the benefits of the tool and built in an exemption process, but unlike ORSA filings that exempt carriers unless the commissioner finds a reason to need the filing, the GCC model exemption process requires all groups to make one, and only one, filing and then seek an exemption from further filings. Texas believes this to be an unnecessarily costly and bureaucratic jumping through the hoops for most groups, particularly in light of all the tools it already has. For those reasons, Texas does not support exposing this current document to make GCC an accreditation standard. Chief Deputy Commissioner Slape stated that it should be an accreditation standard, but only for those groups with international operations and without requiring states to implement a file then exemption process.

Commissioner Clark, Superintendent Toal, Ms. Obusek, Commissioner Rude and Director Deiter stated that they support the Texas position.

Superintendent Cioppa stated that consideration of the federal perspective is part of the discussion, but the real issue is understanding if there is inherent risk to an insurer just for being part of a certain holding company group. The GCC is an analytical tool, and the calculation lets state insurance regulators assess what risks are out there that may not be captured by all the tools that are currently available. It is a tool that will help evaluate not only the group capital on a consistent basis, but it will let state insurance regulators drill down to see what is going on in the group and what poses a risk to the group. It is very important, and state insurance regulators should not lose sight of the fact that, noninsurance entities may pose a risk on the insurance entities, and even a one-time calculation can help provide this insight.

Superintendent Cioppa stated that he respectfully disagrees with those who think this is just a bureaucratic exercise. He said it is a valuable tool that will give state insurance regulators critical insights into the rest of the insurance company group, which, in effect, helps state insurance regulators better protect policyholders. State insurance regulators should not lose sight of this important fact.

Commissioner Mais echoed Superintendent Cioppa and stated that Connecticut supports the GCC. With all the work that has been done on holding company assessments since 2008, this seems like a logical next step. It is not the genesis that some may
think. It gives state insurance regulators insight on group risk that they need. It gives the Lead State a chance to review if there are material risks that have not been identified. If there are none, then it is clear that an exemption is appropriate; but if there are risks, state insurance regulators are one step ahead of the game. This is not a bureaucratic exercise, but something that provides a more quantitative understanding and is a valuable tool to state insurance regulators.

Commissioner Anderson stated that Massachusetts supports the adoption of the GCC for all states. He stated that the list of groups applicable under the Covered Agreements is broader than just IAIGs, but in addition to those groups subject to the Covered Agreements, Commissioner Anderson agrees that the GCC is important to all groups, even if it is just a one-time filing for some. It is important to understand how the non-insurance entities support the operations of the group and how capital is distributed across the entire group. He stated that he appreciates the windows and walls approach that Chief Deputy Commissioner Slape noted, as there are important tools that have been developed previously, but the GCC is the logical extension to group oversight that formalizes and makes consistent how these group tools, along with the GCC as an analytical tool, can be used.

Ms. Belfi stated that the GCC was not developed solely to appease international regulators. If the purpose is solely to appease the international regulators, it would only apply to international business. Early on, the Group Capital Calculation (E) Working Group, made a conscious decision that this was an important tool to be added to the current arsenal of tools for group oversight. The reason the perspective of group capital is so important is that all the current tools referenced, such as Form F or Form B filings, do not contain a lot of aggregated quantitative data, which is the step that the group thought was missing. Filling this gap and creating a more comprehensive view of the group is the reason for the GCC.

Mr. Schrader stated that the GCC is an important tool that was developed as a quantitative tool to pair with many of the qualitative tools at the group level. The need for the tool is not only for groups with international business, but domestic business as well, as it can be useful for all companies. There is an exemption option after the first filing if the state insurance regulator has a good understanding of the risks and does not believe they are significant enough to continue to receive the filing. However, it is important for all groups to complete the calculation at least once to make sure there is a level playing field and that state insurance regulators are treating insurers in groups consistently. Also, whether an insurer is a small part of a large group or a large part of a small group or anywhere in between, each part of the group has a potential risk, and the GCC adds value as a key tool for the state insurance regulators to help assess risk.

Commissioner Anderson commented that it is important to steer away from the premise that the GCC was a response to the Covered Agreements. The GCC discussions began prior to the Covered Agreement discussions, which did not occur until late 2015. The GCC was developed because state insurance regulators, as the leaders of groups, see the value in understanding the entities within the groups that they oversee.

Mr. Rehagen stated that during the development of the GCC there was extensive discussion around exempting certain companies. However, all groups are different, and the Group Capital Calculation (E) Working Group concluded that there is not a way to provide a blanket exemption because of the many differences between each group. Therefore, Model #440 and Model #450 require one filing for all groups prior to allowing an exemption. Once state insurance regulators get the first filing, they can determine whether the filing is needed going forward or an exemption can be granted.

Mr. Wolf agreed that the GCC is a natural building block of the NAIC macroprudential initiative (MPI), and it was not just developed for international reasons. Quantifying the risks within a holding company is important because the risks can emanate anywhere within that holding company structure and can come from any part of the holding company, not just an international entity. In the initial development of the GCC, there were several discussions with federal regulators, who viewed a group capital tool as a national initiative. From the very beginning of development, the GCC was created not just for international purposes, but as a tool to assess the risk of U.S. holding companies as well.

Commissioner Anderson made a motion, seconded by Superintendent Cioppa, to expose the March 8 referral from the Financial Condition (E) Committee regarding the GCC and LST as additions to the accreditation standard for a 30-day public comment period, with the expectation that the normal timeline for adoption of a Part A accreditation standard will be followed, and the effective date for all states will be Jan. 1, 2026. Commissioner Anderson stated that in conjunction with the motion, the Financial Regulation Standards and Accreditation (F) Committee should strongly encourage all states with a group affected by the Covered Agreements to adopt the GCC revisions to Model #440 and Model #450 for those groups effective Nov. 7, 2022. He also stated that the Committee should strongly encourage states with a group affected by the LST to adopt the relevant revisions to Model #440 and Model #450 as soon as possible. The motion passed with Alaska, Arkansas, Connecticut, Hawaii, Maine, Massachusetts, Nebraska and Virginia voting in favor and Kentucky, North Carolina, South Dakota, Texas and Wyoming opposed.
Having no further business, the Financial Regulation Standards and Accreditation (F) Committee adjourned.
MEMORANDUM

TO: Superintendent Elizabeth Kelleher Dwyer (RI), Chair, Financial Regulations Standards and Accreditation (F) Committee and Commissioner Lori K. Wing-Heier, (AK), Vice Chair, Financial Regulations Standards and Accreditation (F) Committee

FROM: Dale Bruggeman (OH), Chair, Statutory Accounting Principles (E) Working Group
       Carrie Mears (IA), Co-Vice Chair, Statutory Accounting Principles (E) Working Group
       Kevin Clark (IA), Co-Vice Chair, Statutory Accounting Principles (E) Working Group

DATE: February 8, 2021


In 2001, the Financial Regulation Standards and Accreditation (F) Committee approved a motion to adopt the Accounting Practices and Procedures Manual – Effective January 1, 2001, Version 1999 (AP&P Manual) as an accreditation standard. The intention of this memorandum is to update the Committee on changes the Statutory Accounting Principles (E) Working Group has made to the AP&P Manual in 2020 through 2021 submission for publication. This memo is to provide the customary annual update regarding changes to the AP&P Manual.

Attachment A to this memo includes a detailed listing of the changes made to the AP&P Manual in 2020. On behalf of the Working Group, it is our opinion that none of these items, either individually or collectively, should be considered “significant” as defined by the financial solvency accreditation standards. Although some of the changes have been categorized as “substantive” by the Working Group, this is not meant to suggest the modifications are synonymous with the term “significant” within the Committee’s context.

As outlined in the NAIC Policy Statement on Maintenance of Statutory Accounting Principles (SAP Policy Statement), modifications will be made to the AP&P Manual each year. As such, it will be reprinted with an “as of” date associated with it. For example, the next printing of the AP&P Manual, which encompasses the attached modifications, will be titled Accounting Practices and Procedures Manual – as of March 2021. This process allows for an efficient way to update the AP&P Manual and virtually guarantees that users have the latest version. Reprints and updates are necessary because of the evolutionary nature of accounting—in both the statutory accounting principles and the generally accepted accounting principles arenas—and are positive for users of the AP&P Manual.

The Working Group sincerely requests that the Committee consider the items listed in Attachment A as “insignificant” changes to the AP&P Manual. We will continue to notify the Committee of any changes to the AP&P Manual and to advise if, in our opinion, those changes are “significant” by financial solvency accreditation standards.

cc Becky Meyer, Sara Franson, Sherry Shull, Robin Marcotte, Julie Gann, Jim Pinegar, Fatima Sediqzad and Jake Stultz
Summary of Changes to the

As of March 2020 Accounting Practices and Procedures Manual

included in the As of March 2021 Manual

The following summarizes changes made to the As of March 2020 Accounting Practices and Procedures Manual (Manual) to create the As of March 2021 version.

Section 1 summarizes substantive revisions to statutory accounting principles. Substantive revisions introduce original or modified accounting principles and can be reflected in an existing or new SSAP. When substantive revisions are made to an existing SSAP, the effective date is identified in the Status section, and the revised text within is depicted by underlines (new language) and strikethroughs (removed language). This tracking will not be shown in subsequent manuals. New and substantively revised SSAPs are commonly accompanied by a corresponding issue paper that reflects the revisions for historical purposes. If language in an existing SSAP is superseded, that language is shaded and the new or substantively revised SSAP is referenced. Completely superseded SSAPs and nullified interpretations are included in Appendix H.

Section 2 summarizes the nonsubstantive revisions to statutory accounting principles. Nonsubstantive revisions are characterized as language clarifications which do not modify the original intent of a SSAP, or changes to reference material. Nonsubstantive revisions are depicted by underlines (new language) and strikethroughs (removed language) and will not be tracked in subsequent manuals. Nonsubstantive revisions are effective when adopted unless a specific effective date is noted.

Section 3 summarizes revisions to the Manual appendices.

1. Substantive Revisions – Statutory Accounting Principles

<table>
<thead>
<tr>
<th>Section</th>
<th>Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSAP No. 32R</td>
<td>2019-04</td>
<td>Revisions update the definitions, measurement and impairment guidance for preferred stock pursuant to the investment classification project.</td>
</tr>
<tr>
<td>SSAP No. 105R</td>
<td>2019-25</td>
<td>Revisions provide updates to the Working Capital Finance Investments Program requirements. In addition, Issue Paper No. 163 was issued to provide historical documentation of the adopted revisions.</td>
</tr>
<tr>
<td>SSAP No. 106</td>
<td>2020-05</td>
<td>Revisions supersede SSAP No. 106 and nullify Interpretation (INT) 18-02: ACA Section 9010 Assessment Moratoriums. In 2021, annual statement revisions removed related disclosures.</td>
</tr>
</tbody>
</table>

2. Nonsubstantive Revisions – Statutory Accounting Principles

<table>
<thead>
<tr>
<th>Section</th>
<th>Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSAP No. 2R</td>
<td>2019-20</td>
<td>Revisions incorporate additional concepts which restrict the classification of certain related party or affiliated investments as a cash equivalent or short-term investment. An additional disclosure was adopted to identify short-term investments (or substantially similar investments) which remain on the short-term schedule for more than one consecutive year.</td>
</tr>
<tr>
<td>2019-42</td>
<td>Revisions reflect that certain cash/liquidity pools meeting defined criteria shall be reported as cash equivalents.</td>
<td></td>
</tr>
<tr>
<td>2020-16EP</td>
<td>Revisions update the reporting line for qualifying cash pools and make other paragraph referencing edits.</td>
<td></td>
</tr>
<tr>
<td>2020-20</td>
<td>Revisions expand current “rolled” short-term investments disclosures (as adopted in 2019-20) to include certain cash equivalent investments.</td>
<td></td>
</tr>
</tbody>
</table>
| SSAP No. 5R | 2018-26 | Revisions state that the reported equity method losses of an SCA will not go negative (thus stop at zero unless there are other valuation adjustments). However,
<table>
<thead>
<tr>
<th>Year</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019-43</td>
<td>SSAP No. 5R</td>
<td>Revisions reject ASU 2017-11, Earnings Per Share, Distinguishing Liabilities from Equity, Derivatives &amp; Hedging and incorporate guidance for when certain freestanding instruments shall be recognized as liabilities.</td>
</tr>
<tr>
<td>2020-25EP</td>
<td>SSAP No. 5R</td>
<td>Revisions remove redundant paragraph references in SSAP No. 5R.</td>
</tr>
<tr>
<td>2020-23</td>
<td>SSAP No. 5R</td>
<td>Revisions update the amortization guidance for leasehold improvements. The updated language will allow leasehold improvements to have lives that match the associated “lease term” as reflected in SSAP No. 22R.</td>
</tr>
<tr>
<td>2020-06EP</td>
<td>SSAP No. 5R</td>
<td>Adopted editorial revisions which remove quoted guidance.</td>
</tr>
<tr>
<td>2019-33</td>
<td>SSAP No. 25</td>
<td>Revisions data-capture existing narrative format disclosures from SSAP No. 25.</td>
</tr>
<tr>
<td>2020-01</td>
<td>SSAP No. 26R</td>
<td>Revisions eliminate references to the NAIC Bond Fund List (Bond List) in SSAP No. 26R and add reference to the “NAIC Fixed Income-Like SEC Registered Funds List” in SSAP No. 30R.</td>
</tr>
<tr>
<td>2020-02</td>
<td>SSAP No. 26R</td>
<td>Revisions clarify that the accounting and reporting of investment income and capital gain/loss, due to the early liquidation either through a called bond or a bond tender offer, shall be similarly applied.</td>
</tr>
<tr>
<td>2020-14</td>
<td>SSAP No. 26R</td>
<td>Revisions clarify the assessment of other-than-temporary impairment (OTTI) to require use of modified contract terms. These revisions provide consistency with guidance in SSAP No. 36R—Troubled Debt Restructuring and SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities.</td>
</tr>
<tr>
<td>2020-01</td>
<td>SSAP No. 30R</td>
<td>Revisions eliminate references to the NAIC Bond Fund List (Bond List) in SSAP No. 26R and add reference to the “NAIC Fixed Income-Like SEC Registered Funds List” in SSAP No. 30R.</td>
</tr>
<tr>
<td>2020-31</td>
<td>SSAP No. 32R</td>
<td>Revisions permit early adoption of the substantively revised SSAP No. 32R—Preferred Stock.</td>
</tr>
<tr>
<td>2020-19</td>
<td>SSAP No. 37</td>
<td>Revisions clarify that the “financial rights and obligations” required for a loan participation are not required to extend beyond the attachment of cashflows.</td>
</tr>
<tr>
<td>2019-37</td>
<td>SSAP No. 41R</td>
<td>Revisions require additional disclosures regarding the issuance of surplus notes, specifically for those that are structured in a manner in which cash flows have been reduced or eliminated.</td>
</tr>
<tr>
<td>2019-41</td>
<td>SSAP No. 43R</td>
<td>This item was disposed without statutory revisions.</td>
</tr>
<tr>
<td>2020-21</td>
<td>SSAP No. 47</td>
<td>Revisions reflect the recently updated final NAIC designation category guidance for RMBS/CMBs securities as recently adopted by the Valuation of Securities (E) Task Force in the P&amp;P manual.</td>
</tr>
<tr>
<td>2020-28</td>
<td>SSAP No. 51R</td>
<td>Revisions add consistency edits to ensure separate account guaranteed products are referenced in all applicable paragraphs of the withdrawal characteristics disclosure, correct an identified inconsistency in a new disclosure, and adds a cross-reference to the existing disclosures.</td>
</tr>
</tbody>
</table>
| 2020-04 | SSAP No. 51R | Revisions specify that voluntary decisions to choose one allowable reserving methodology over another, which requires commissioner approval under the
<table>
<thead>
<tr>
<th>SSAP No.</th>
<th>Year</th>
<th>Revisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>52</td>
<td>2020-04</td>
<td>Revisions specify that voluntary decisions to choose one allowable reserving methodology over another, which requires commissioner approval under the <em>Valuation Manual</em>, shall be reported and disclosed as a change in valuation basis.</td>
</tr>
<tr>
<td>53</td>
<td>2019-40</td>
<td>Revisions clarify that existing installment fee revenue guidance should be narrowly applied.</td>
</tr>
<tr>
<td>54R</td>
<td>2020-04</td>
<td>Revisions specify that voluntary decisions to choose one allowable reserving methodology over another, which requires commissioner approval under the <em>Valuation Manual</em>, shall be reported and disclosed as a change in valuation basis.</td>
</tr>
<tr>
<td>55</td>
<td>2018-38</td>
<td>Revisions clarify that loss and loss adjusting expense liabilities are established regardless of payments to third parties (except for capitated health claim payments).</td>
</tr>
<tr>
<td>56</td>
<td>2019-35</td>
<td>Revisions add consistency edits to ensure separate account guaranteed products are referenced in all applicable paragraphs of the withdrawal characteristics disclosure, correct an identified inconsistency in a new disclosure, and adds a cross-reference to the existing disclosures.</td>
</tr>
<tr>
<td>61R</td>
<td>2019-35</td>
<td>Revisions add consistency edits to ensure separate account guaranteed products are referenced in all applicable paragraphs of the withdrawal characteristics disclosure, correct an identified inconsistency in a new disclosure, and adds a cross-reference to the existing disclosures.</td>
</tr>
<tr>
<td>68</td>
<td>2020-03</td>
<td>Revisions add disclosure elements for reported goodwill.</td>
</tr>
<tr>
<td>72</td>
<td>2019-43</td>
<td>Revisions reject ASU 2017-11, <em>Earnings Per Share, Distinguishing Liabilities from Equity, Derivatives &amp; Hedging</em> and incorporate guidance for when certain freestanding instruments shall be recognized as liabilities.</td>
</tr>
<tr>
<td>73</td>
<td>2020-23</td>
<td>Revisions update the amortization guidance for leasehold improvements. The updated language will allow leasehold improvements to have lives that match the associated “lease term” as reflected in SSAP No. 22R.</td>
</tr>
<tr>
<td>86</td>
<td>2019-38</td>
<td>Revisions ensure reporting consistency in that derivatives are reported “gross;” i.e., without the inclusion of financing components. Additionally, amounts owed to/from the reporting entity from the acquisition or writing of derivatives shall be separately reflected.</td>
</tr>
<tr>
<td></td>
<td>2019-39</td>
<td>This agenda item was disposed without statutory accounting revisions.</td>
</tr>
<tr>
<td>87</td>
<td>2019-43</td>
<td>Revisions reject ASU 2017-11, <em>Earnings Per Share, Distinguishing Liabilities from Equity, Derivatives &amp; Hedging</em> and incorporate guidance for when certain freestanding instruments shall be recognized as liabilities.</td>
</tr>
<tr>
<td>97</td>
<td>2018-26</td>
<td>Revisions state that the reported equity method losses of an SCA will not go negative (thus stop at zero unless there are other valuation adjustments). However, to the extent there is a financial guarantee or commitment, the guarantee or commitment would be captured in SSAP No 5R.</td>
</tr>
<tr>
<td></td>
<td>2019-32</td>
<td>Revisions clarify that a more-than-one holding company structure is permitted as a look-through if each of the holding companies within the structure complies with the look-through requirements in SSAP No. 97.</td>
</tr>
</tbody>
</table>
|         | 2020-17 | Revisions update 1) the descriptive language regarding the SCA review and 2) the communication process of completed SCA reviews for both domestic regulators.
and financial statement filers. The change in delivery of SCA review documents will occur on January 1, 2021.

<table>
<thead>
<tr>
<th>Reference</th>
<th>Description</th>
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<tbody>
<tr>
<td>2020-18</td>
<td>Revisions remove a superseded statement that guarantees or commitments from the insurance reporting entity to the SCA could result in a negative equity valuation of the SCA.</td>
</tr>
<tr>
<td>2020-28</td>
<td>Revisions reject ASU 2020-01, Investments—Equity Securities (Topic 321), Investments—Equity Method and Joint Ventures (Topic 323), and Derivatives and Hedging (Topic 815), Clarifying the Interactions between Topic 321, Topic 323 and Topic 815 for statutory accounting.</td>
</tr>
<tr>
<td>SSAP No. 103R 2019-20</td>
<td>Revisions incorporate additional concepts to restrict the classification of related party or affiliated investments as a cash equivalent or short-term investment. An additional disclosure identifies short-term investments (or substantially similar investments) which remain on the short-term schedule for more than one consecutive year.</td>
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</tbody>
</table>

3. Revisions to the Appendices

<table>
<thead>
<tr>
<th>Section</th>
<th>Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A 2020-07</td>
<td>Revisions add a line for Total Valuation Allowance to Appendix A-001—Investments of Reporting Entities, Section 3, Summary Investment Schedule.</td>
<td></td>
</tr>
<tr>
<td>2020-05</td>
<td>Revisions supersede SSAP No. 106—Affordable Care Act 9010 Assessment and nullify Interpretation (INT) 18-02: ACA Section 9010 Assessment Moratoriums. In 2021, annual statement revisions removed related disclosures.</td>
<td></td>
</tr>
<tr>
<td>2020-12</td>
<td>New INT 20-01: ASU 2020-04, Reference Rate Reform provides optional expedient guidance, allowing for the continuation of certain contracts that are modified in response to reference rate reform. Additionally, it provides waivers from derecognizing hedging transactions, and exceptions for assessing hedge effectiveness as a result of transitioning away from certain interbank offering rates.</td>
<td></td>
</tr>
<tr>
<td>Appendix B INT 20-03</td>
<td>Temporary INT 20-03: Troubled Debt Restructuring Due to COVID-19 clarifies that a modification of mortgage loan or bank loan terms in response to COVID-19 shall follow the provisions detailed in the April 7, 2020, “Interagency Statement on Loan Modifications and Reporting for Financial Institutions Working with Customers Affected by the Coronavirus,” and the provisions of the CARES Act in determining whether the modification shall be reported as a troubled debt restructuring. Revisions to INT 20-03 in response to the December 27, 2020, extension of the federal CARES Act extended the INT until the earlier of January 1, 2022, or 60 days after the national emergency regarding COVID-19 terminates.</td>
<td></td>
</tr>
<tr>
<td>INT 20-06</td>
<td>New INT 20-06: Participation in the 2020 TALF Program provides an exception to allow admitted asset reporting for pledged securities although the TALF program does not permit the pledged assets to be generally substitutable.</td>
<td></td>
</tr>
</tbody>
</table>
| INT 20-07 | Temporary INT 20-07: Troubled Debt Restructuring of Certain Debt Investments Due to COVID-19 provides practical expedients in assessing whether modifications in response to COVID-19 are insignificant under
<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>C</strong></td>
<td>AG 49</td>
</tr>
<tr>
<td></td>
<td>AG 49-A</td>
</tr>
<tr>
<td><strong>D</strong></td>
<td>Rejected as Not Applicable to Statutory Accounting:</td>
</tr>
<tr>
<td>2019-46</td>
<td>ASU 2016-14, Presentation of Financial Statements of Not-for-Profit Entities</td>
</tr>
<tr>
<td>2020-10</td>
<td>ASU 2017-14, Amendments to SEC Paragraphs in Topic 220, Topic 605 and Topic 606</td>
</tr>
<tr>
<td>2020-11</td>
<td>ASU 2020-02, Amendments to SEC Paragraphs in Credit Losses (Topic 326) and Leases (Topic 842)</td>
</tr>
<tr>
<td>2020-26</td>
<td>ASU 2015-10, Technical Corrections &amp; Improvements</td>
</tr>
<tr>
<td>2020-27</td>
<td>ASU 2019-09, Financial Services – Insurance: Effective Date</td>
</tr>
<tr>
<td>2020-29</td>
<td>ASU 2020-05, Revenue from Contracts with Customers (Topic 606) and Leases (Topic 842), Effective Dates for Certain Entities</td>
</tr>
<tr>
<td><strong>E</strong></td>
<td>2019-25</td>
</tr>
<tr>
<td>2019-04</td>
<td>Issue Paper No. 164—Preferred Stock documents substantive revisions in SSAP No. 32R to update the definitions, measurement and impairment guidance for preferred stock pursuant to the investment classification project.</td>
</tr>
<tr>
<td><strong>F</strong></td>
<td>No revisions impacting this appendix were adopted in 2020.</td>
</tr>
<tr>
<td><strong>G</strong></td>
<td>No revisions impacting this appendix were adopted in 2020.</td>
</tr>
<tr>
<td><strong>H</strong></td>
<td>2020-05</td>
</tr>
<tr>
<td></td>
<td>Revisions supersede SSAP No. 106—Affordable Care Act 9010 Assessment and nullify Interpretation (INT) 18-02: ACA Section 9010 Assessment Moratoriums as of year-end 2020. In 2021, annual statement revisions removed related disclosures.</td>
</tr>
<tr>
<td>INT 20-04</td>
<td>Temporary INT 20-04: <em>Mortgage Loan Impairment Assessment Due to COVID-19</em> provides limited-time exceptions to defer the assessment of impairment for certain bank loans, mortgage loans and investments that predominantly hold underlying mortgage loans, which are affected by forbearance or modifications in response to COVID-19. This Interpretation expired at the end of the third quarter 2020.</td>
</tr>
<tr>
<td>INT 20-05</td>
<td>Temporary INT 20-05: <em>Investment Income Due and Accrued</em> provides limited-time collectibility assessments and admittance exceptions for SSAP No. 34—<em>Investment Income Due and Accrued</em>. This interpretation allows an exception to the collectibility assessment for investments that have had a forbearance or modifications in response to COVID-19 that were both current as of December 31, 2019, and were not experiencing financial difficulties at the time of the modification. For these items, further evaluation of collectibility would not be required unless other indicators that interest would not be collected were known. This Interpretation expired at the end of the third quarter 2020.</td>
</tr>
<tr>
<td>INT 20-08</td>
<td>Temporary INT 20-08: <em>COVID-19 Premium Refunds, Limited-Time Exception, Rate Reductions and Policyholder Dividends</em> addresses the accounting and disclosures of the various forms of policyholder payments made due to decreased activity from COVID-19. This Interpretation was in effect through year-end 2020 and nullified automatically on January 1, 2021.</td>
</tr>
<tr>
<td>INT 20-11</td>
<td>Temporary INT 20-11: <em>Extension of Ninety-Day Rule for the Impact of 2020 Hurricanes, California Wildfires and Iowa Windstorms</em> provides a 60-day extension from the ninety-day rule for uncollected premium balances, bills receivable and amounts due from agents and for policies directly impacted by the noted 2020 hurricanes, California wildfires and Iowa windstorms. This interpretation was in effect through year-end 2020 and nullified automatically on February 28, 2021.</td>
</tr>
</tbody>
</table>
TO: Honorable Elizabeth Kelleher Dwyer, Chair
   Financial Regulation Standards & Accreditation (F) Committee

FROM: Jake Garn, Utah Chief Financial Examiner, Chair Blanks (E) Working Group

DATE: March 23, 2021

RE: Items Impacting Current Accreditation Standard

Please find attached a list of items adopted by the Blanks (E) Working Group during 2020. The Blanks Working Group adopts numerous changes to the Annual Statement Blanks and Instructions each year. Most of the changes are made to clarify current requirements or are considered enhancements to existing reporting. The changes adopted in 2020 do not represent a substantive change to any reporting requirements.

I am planning to be present when the Financial Regulation Standards & Accreditation (F) Committee meets in the event any member of the committee wishes to discuss these issues.
Changes to blanks and instructions adopted during 2020


3. Modify the instruction and blank for Supplemental Investment Risk Interrogatories question 14.01 to clarify that interrogatories 14.06 through 14.15 are to be completed regardless of the answer to Supplemental Investment Risk Interrogatories question 14.01 (2019-29BWG) Effective Dec. 31, 2020.


5. Add crosschecks to lines 13 and 14 of the Exhibit of Premiums Enrollment and Utilization (State Page) to lines 10 and 11 of the Underwriting and Investment Exhibit, Part 1. Add crosschecks to lines 9, 10 and 11 of the Underwriting and Investment Exhibit, Part 1 and Schedule T, line 61 (2020-01BWG) Effective Dec. 31, 2020.


10. Add a disclosure instruction for 10C to the Notes to the Financial Statement for related party transactions not captured on Schedule Y to reflect the disclosure addition for SSAP No. 25—Affiliates and Other Related Parties adopted by the Statutory Accounting Principles (E) Working Group. Combine existing 10C into 1B instructions and illustration narrative (2020-08BWG) Effective Dec. 31, 2020.

11. Modify the Annual Statement Instructions for Schedule F, Part 3 to reflect the factors for all uncollateralized reinsurance recoverable from unrated reinsurers be the same for authorized, unauthorized, certified, and reciprocal reinsurance (2020-09BWG) Effective Dec. 31, 2020.

12. Revise the column 10 header in the Variables Annuities Supplement blank to be contract level reserves less cash surrender value. Revise the line descriptions in lines 1 through 3 in the footer and add a Line for the reserve credit from other reinsurance and for post-reinsurance ceded aggregate reserve. Adjust the instructions to correspond with changes made to the blanks as well as changes in the 2020 Valuation Manual for the new variable annuities framework (2020-10BWG) Effective Dec. 31, 2020.

13. For the VM-20 Reserves Supplement Blank, split Part 1 into Part 1A and Part 1B. For Part 1A: change the description header for column 3 to be “Due and Deferred Premium Asset” to match the instructions. Add “XXX” in the two places needed to indicate that a due and deferred premium asset does not need to be reported in the lines shown for Total Reserves. Change the reporting units for all columns to be in dollars rather than in thousands. Expand all columns to allow room for a number as large as 999,999,999,999. Change the product labels for clarity. For Part 1B: change the reporting units for the reserve columns to be in dollars rather than in thousands. Expand the reserve columns to allow room for a number as large as 999,999,999,999. Expand the face amount columns to allow...
room for a number as large as 9,999,999,999. Change the product labels for clarity. Remove Part 2 and renumbering the remaining parts. Adjust the instructions according to the changes made to the banks. Clarify instructions and add examples for Parts 1A and 1B (2020-11BWG) Effective Dec. 31, 2020.


16. Modify the columns and rows on the blank pages for the Long-Term Care Experience Reporting Forms 1 through 5 and make appropriate changes to the instructions for those forms (2020-14BWG) Effective Dec. 31, 2020.

17. Add a new private flood insurance supplement collecting residential and commercial private flood insurance data and revisions to the Credit Insurance Experience Exhibit (CIEE) to collect lender-placed flood coverages (2020-15BWG) Effective Dec. 31, 2020.


19. Adjust the Asset Valuation Reserve (AVR) presentation to include separate lines for each of the expanded bond designation categories (2020-17BWG) Effective Dec. 31, 2020.

20. Clarify the instructions to indicate which funds reported on Schedule D, Part 2, Section 2 (Annual Filing) and Schedules D, Part 3 and 4 (Quarterly Filing) must have NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol. Modify the reference to the Purposes and Procedures Manual of the NAIC Investment Analysis Office found in the investment instructions (2020-18BWG) Effective Dec. 31, 2020.

21. Add a code of “%” to the Code Column for all investments which have been reported Schedule DA, Part 1 and Schedule E, Part 2 for more than one consecutive year. Add certification to the General Interrogatories, Part 1 inclusion of these investments on Schedule DA, Part 1 and Schedule E, Part 2 (2020-19BWG) Effective Dec. 31, 2020.


23. Add new line 4.05 for valuation allowance for mortgage loans to the Summary Investment Schedule and renumber existing line 4.05 to 4.06. Modify the instructions to include a crosscheck for new line 4.05 back to Schedule B – Verification Between Years. Clarify the instructions for 4.01-4.04 to explicitly show crosschecking to column 8 of Schedule B, Part 1 (2020-21BWG) Effective Dec. 31, 2020.

24. Modify the instructions and illustration for Note 3A and a new Note 3E with instructions and illustrations to be data captured. Modify the blank and instructions for Schedule D, Part 6, Sections 1 and 2 (2020-22BWG) Effective Dec. 31, 2020.

25. Add a footnote to Exhibit 5 (life/fraternal & health – life supplement) and Exhibit 3 (Separate Accounts) to disclose cases when a mortality risk is no longer present or a significant factor – i.e. due to a policyholder electing a payout benefit (2020-23BWG) Effective Dec. 31, 2020.

26. Remove questions 29, 30, 31 and 32 from the Supplemental Exhibits and Schedules Interrogatories. Renumber the remaining questions. Remove the instructions related to these actuarial filings (2020-24BWG) Effective 12/31/2021.

27. Add a new column 5 to the blank for Schedule T with instructions to specifically capture the Children’s Health Insurance Program (CHIP) premium. Existing columns after the new column 5 will be renumbered (2020-25BWG) Effective 1/1/2021.

28. Add a new column 5 to Schedule DB, Part D, Section 1 and renumber the remaining columns. Add instructions for the new column 5, add the column reference to column 7 and adjust other column references in crosschecks. Correct column references for this schedule on the Liability Page, Asset Page and Schedule DB Verification. Modify instruction language for the disclosure Note 8A(8) (2020-26BWG) Effective 1/1/2021.


30. Remove the disclosure for the Federal Affordable Care Act (ACA) Section 9010 Assessment from Note 22 – Events Subsequent (SAPWG Ref #2020-05) (2020-28BWG) Effective 12/31/2021.
31. Remove the line category and reference to the NAIC Bond Fund List (Bond List) from the investment schedule instructions and blank (SAPWG 2020-01) (2020-29BWG) Effective 12/31/2021.

32. Move the interrogatory question regarding Communication of Internal Control Related Matters Noted in Audit from the Annual Supplemental Exhibits and Schedules Interrogatories to the Quarterly Supplemental Exhibits and Schedules Interrogatories to be answered for the second quarter. For title, a new page in the quarterly statement will be added for the Supplemental Exhibits and Schedules Interrogatories (2020-30BWG) Effective 12/31/2021.

To: The Financial Regulation Standards and Accreditation (F) Committee  
From: Susan Bernard, Chair, Financial Examiners Handbook (E) Technical Group  
Date: February 26, 2021  
Subject: Consideration for Financial Accreditation Standards  

2021 Financial Condition Examiners Handbook

The Accreditation Program Manual includes Review Team Guidelines to be used for financial examinations performed using the risk-focused surveillance approach that is found in the NAIC Financial Condition Examiners Handbook (the Handbook). This memorandum is to update the FRSAC on changes that the Financial Examiners Handbook Technical Group (FEHTG) has made to the Handbook during 2020.

Modifications are made to the Handbook each year, and a new edition is published annually. This process allows for an efficient way to update the Handbook and ensures that users have the latest version. The FEHTG made several changes to the Handbook in 2020. It is the FEHTG’s opinion that none of these changes should be considered “significant” for accreditation purposes. FEHTG defined “significant” as a change that may immediately warrant a change to at least one accreditation standard or the Review Team Guideline(s) for said standard. Although some changes may be categorized as “significant” by the FEHTG, this is not meant to suggest the modifications are synonymous with the term “significant” within the FRSAC context.

During 2020, the FEHTG made the following changes:

- Revised the reinsurance guidance to include a definition of a reciprocal jurisdiction reinsurer and describe the related requirements for obtaining credit for reinsurance. These revisions were made in accordance with the updates to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786), which extend the ability for U.S ceding insurers to obtain credit for reinsurance ceded to reinsurers from Reciprocal Jurisdictions with no collateral requirements.

- Revised guidance to incorporate the following Long-Term Care Insurance (LTCI) considerations:
  - Additional narrative background guidance to the life insurance reserves review chapter of the Handbook, covering actuarial asset adequacy and reserve increase factors, which includes morbidity assumptions and rate increases.
  - New risks and related procedures added into the Reserves/Claims Handling (Life) and Underwriting exam repositories for LTCI policies. These related to assumptions utilized when calculating the policy’s reserves for and establishing appropriate policy rates.
  - Additional possible questions added to Exhibit Y – Examination Interviews, which the examiner may consider asking when interviewing the Chief Actuary.
• Revised the definition of a qualified actuary per the P/C Statement of Actuarial Opinion. Additionally, the Reserves/Claims Handling (P/C) exam repository was updated to add clarity to certain risk statements and procedures and Exhibit M – Corporate Governance was updated to add considerations when assessing management oversight of the actuarial function.

• Revisions to the Own Risk and Solvency Assessment (ORSA) related guidance within the Handbook, which included the following:
  
  o Possible procedures the exam team could perform to verify and validate the information in the ORSA.
  o Updates to Exhibit M – Corporate Governance to clarify the link between the ORSA information and Exhibit AA – Summary Review Memorandum (SRM).
  o Updates to the SRM to include details on how the exam team should conclude on the maturity of the insurer’s ORSA/ERM function.
  o Updates to the SRM to include new guidance describing the expectation that the exam team should include the results of the ORSA/ERM review in the branded risk assessments, where applicable.

• Revisions to the Reserves/Claims Handling Repositories (Life, Health and P/C) as part of the annual repository maintenance to ensure the repositories contain appropriate and relevant risks and procedures. As part of this project, some minor revisions were also added to the narrative guidance related to life insurance reserves reviews.

• Revised guidance related to Information Technology (IT) with the addition of “cyber self-assessment tools” to the list of items requested at the beginning of an IT examination within the Information Technology Planning Questionnaire (ITPQ).

The FEHTG sincerely requests that the FRSAC consider the items listed above as insignificant changes to the Handbook. We will continue to notify the FRSAC of any changes to the Handbook and advise if, in our opinion, those changes are “significant” by accreditation expectations.
MEMORANDUM

TO: Superintendent Elizabeth Kelleher Dwyer, Chair
   Financial Regulation Standards and Accreditation (F) Committee

FROM: Tom Botsko, Chair
   Capital Adequacy (E) Task Force

DATE: February 1, 2021

RE: Accreditation Standards – Changes to the RBC Formulas and Instructions for Health, Life and P/C

Attached please find a brief description of changes to the 2020 Risk-Based Capital Report Including Overview and Instructions for health, life and property/casualty (P/C). These changes were adopted by the Capital Adequacy (E) Task Force and Executive (EX) Committee and Plenary in 2020. Significance of these changes was viewed as it relates to the overall risk-based capital (RBC) standard.

No changes to the RBC formulas or instructions were deemed to be significant for health, life or P/C.

Any questions can be directed to NAIC staff:
P/C – Eva Yeung
Life – Dave Fleming
Health — Crystal Brown

Health RBC Formula

Not Significant Capitation tables included in the forecasting spreadsheet will be captured electronically through the annual filing submission of the health RBC formula.

Not Significant The Risk-Based Capital Preamble was added to the Health RBC instructions to clarify the purpose and goals of RBC as the Task Force and Working Groups review referrals and proposals.

Not Significant The 20 designation bond categories were incorporated into the health RBC formula for year-end 2020 reporting. The information captured through the 2020 reporting will be used to conduct an impact analysis that will assist in determining the final bond factors. The 20 bond designation categories were incorporated on an informational only basis on the Off-Balance Sheet Security Lending Collateral and Schedule DL, Part 1 Assets Page (XR006), Fixed Income Assets page (XR007) and the Asset Concentration page (XR011).

Not Significant The instructions were modified on page iv to insert the word “Overview” in the page heading and the Table of Contents was modified to include only the page heading and delete references to the individual sections of the Overview page.

Life RBC Formula

Not Significant Capitation tables included in the forecasting spreadsheet will be captured electronically through the annual filing submission of the life RBC formula.
Not Significant  The Risk-Based Capital Preamble was added to the life RBC instructions to clarify the purpose and goals of RBC as the Task Force and Working Groups review referrals and proposals.

Not Significant  The 20 designation bond categories were incorporated into the life RBC formula for year-end 2020 reporting. The information captured through the 2020 reporting will be used to conduct an impact analysis that will assist in determining the final bond factors.

Not Significant  The instructions were modified on page iv to insert the word “Overview” in the page heading and the Table of Contents was modified to include only the page heading and delete references to the individual sections of the Overview page.

Not Significant  The structure for a longevity risk charge was incorporated into the life RBC formula along with the instructions which include factors of zero for 2020. The structure adopted will provide information to be used in the ultimate determination of factors for 2021.

P/C RBC Formula

Not Significant  Capitation tables included in the forecasting spreadsheet will be captured electronically through the annual filing submission of the P/C RBC formula.

Not Significant  Modify the instruction to reflect the factors for all uncollateralized reinsurance recoverable from unrated reinsurers be the same for authorized, unauthorized, certified, and reciprocal reinsurance.

Not Significant  The Risk-Based Capital Preamble was added to the P/C RBC instructions to clarify the purpose and goals of RBC as the Task Force and Working Groups review referrals and proposals.

Not Significant  Clarify the instructions for the reinsurance recoverable from individual syndicates of Lloyds’ of London that are covered under the Lloyd’s Central Fund may utilize the lowest financial strength group rating received from an approved rating agency.

Not Significant  Eliminate PR038 Adjustment for Reinsurance Penalty for Affiliates Applicable to Schedule F section.

Not Significant  The 20 designation bond categories were incorporated into the P/C RBC formula for year-end 2020 reporting. The information captured through the 2020 reporting will be used to conduct an impact analysis that will assist in determining the final bond factors. The 20 bond designation categories were incorporated on an informational only basis on the Bonds Page (PR006), the Asset Concentration page (PR011) and Off-Balance Sheet Collateral and Schedule DL, Part 1 Assets Page (PR015).

Not Significant  The PR017 and PR018 Line 1 industry average development factors were updated.

Not Significant  The instructions were modified on page iv to insert the word “Overview” in the page heading and the Table of Contents was modified to include only the page heading and delete references to the individual sections of the Overview page.
MEMORANDUM

TO: Financial Regulation Standards and Accreditation (F) Committee
FROM: Kevin Fry (Ill), Chair Valuation of Securities (E) Task Force
Charles Therriault, Director, NAIC Securities Valuation Office

CC: Dan Daveline, Director, NAIC Financial Regulatory Services
Mark Perlman, Managing Investment Counsel, NAIC Securities Valuation Office

DATE: February 16, 2021

RE: Report of the Valuation of Securities (E) Task Force

A. Purpose – This report is presented to assist the Financial Regulation Standards and Accreditation (F) Committee to determine if amendments to the Purposes and Procedures Manual of the NAIC Investment Analysis Office adopted by the Valuation of Securities (E) Task Force in 2020 require corresponding changes in either the Financial Regulation Standards (defined below) or state laws or regulations adopted in conformity with Part A: Laws and Regulations of the Financial Regulation Standards.

B. Financial Regulation Standards – The NAIC Policy Statement on Financial Regulation Standards (SFRS) in the 2021 Accreditation Program Manual consists of four parts: Part A identifies laws and regulations deemed necessary to financial solvency regulation; Part B identifies regulatory practices and procedures that supplement and support enforcement of the financial solvency laws and regulations discussed in Part A; Part C contains three standards related to an insurance department’s organizational and personnel policies; and Part D focuses on Organization, licensing and change of control of domestic insurers. This report is concerned with the financial solvency standards in Part A. Those standards relevant to this report are shown immediately below and can be characterized as NAIC model legislation, codified NAIC guidance (i.e., the Accounting Practices and Procedures Manual): analytical work product of the NAIC staff (including the NAIC Investment Analysis Office) and state laws and regulations that contain substantially the same standards as NAIC model legislation or guidance. A review indicates that the work product of the NAIC Investment Analysis Office is directly or indirectly incorporated into the following Part A standards. For example:

- **Standard 5** requires that insurer owned securities be valued in accordance with the standards promulgated by the NAIC Investment Analysis Office;
- **Standard 2**, the Risk-Based Capital (RBC) for Insurers Model Act assigns RBC factors for securities based on their credit risk as measured by NAIC Designations;
- **Standard 3**, the Accounting Practices and Procedures Manual uses NAIC Designations produced by the SVO or by insurers through the filing exempt process and or Price Grids produced by the SSG to identify valuation rules applicable to an investment and the reserved capital amount the insurer must report;
Standard 8, pertaining to state investment regulations often incorporate NAIC mechanisms that relate asset allocations to credit risk expressed in the form of NAIC Designations; and

Standard 10, the Credit for Reinsurance Model Act (¶785) identifies insurer owned securities compiled by the SVO into a List of Investment Securities published quarterly in the NAIC AVS + Plus product, and letters of credits issued by the banks on the NAIC Bank List administered by the SVO, as eligible for use as collateral in reinsurance transactions.

C. Investment Analysis Office Standards Identified in the Purposes and Procedures Manual – All SVO and SSG standards related to the assessment of credit risk in insurer owned securities, identification of additional non-payment risk in securities, classification of certain assets as bonds or as bond-like for reporting purposes, the valuation of insurer owned securities, and other activities conducted by the SVO or the SSG in support of state insurance regulatory objectives, are determined and promulgated by the Valuation of Securities (E) Task Force and published in the Purposes and Procedures Manual. In 2020, the Purposes and Procedures Manual was revised once, in December, with all policies, analytical procedures and instructions adopted during 2020 effective for year-end financial reporting. Amendments to the Purposes and Procedures Manual would automatically be reflected in the SFRS if any or all of the SFRS Standards identified in paragraph A of this memorandum have been adopted by an accredited state or incorporated by reference into the laws or regulations of an accredited state. For example, amendments to the Purposes and Procedures Manual would be directly incorporated by reference if the laws or regulations of an accredited state refer to or incorporate Standard 5 on valuation. Amendments to the Purposes and Procedures Manual would be indirectly incorporated by reference if the law or regulations of a state refers to or incorporates any other Standard that itself uses NAIC Designations or other analytical products of the Investment Analysis Office as a component; for example, Standard 2 in the case of RBC and/or Standard 3 in the case of statutory accounting.

D. Conclusion – In our opinion, reasoning as discussed above, amendments to the Purposes and Procedures Manual adopted by the Valuation of Securities (E) Task Force in 2020 can be characterized as maintenance items consistent with the existing regulatory framework and automatically incorporated into the Part A Standards identified above. The amendments identified in Attachments One did not create processes or practices external to the Purposes and Procedures Manual or other NAIC model legislation, guidance or analysis of NAIC staff that would suggest the need to consider an amendment to NAIC model legislation or guidance or legislative action on the part of an accredited state.

We hope this is responsive to the issues and concerns before the Committee.
Attachment One

RECENT CHANGES TO THE PURPOSES AND PROCEDURES MANUAL
Published in the December 31, 2020 Publication

- Adopted updates following a new SEC rule affecting exchange-traded funds – On Sep. 26, 2019, the SEC adopted rule 6c-11 (the “Rule”) under the Investment Company Act of 1940 (the “Act”) which will permit exchange-traded funds (“ETFs”) that satisfy certain conditions to operate without first obtaining an exemptive order from the SEC under the Act. The SEC has stated that the intent of the rule is to modernize the regulatory framework for ETFs by reducing expenses and delays in creating new ETFs, to promote greater consistency, transparency and efficiency for ETFs and to facilitate greater competition among ETFs. The Rule becomes effective Dec. 23, 2019, followed by a one year transition period for compliance. The amendment removed references to SEC exemptive orders from descriptions of ETFs and clarify that Regulatory Treatment Analysis Service application filers only need to provide SEC exemptive orders to the SVO when applicable.

The Valuation of Securities (E) Task Force adopted this amendment on Feb. 4, 2020

- Updated instructions for financial modeled RMBS/CMBS securities to map NAIC Designations to NAIC Designations Categories – Financial Modeled RMBS/CMBS securities use their book/adjusted carrying value price ranges to determine an NAIC Designation. The resulting NAIC Designation from financial modeling process will be now be mapped to an NAIC Designation Category; except that an RMBS or CMBS tranche that has no expected loss under any of the selected modeling scenarios and that would be equivalent to an NAIC 1 Designation and NAIC 1.A Designation Category if the filing exempt process were used, would be assigned an NAIC 1 Designation and NAIC 1.A Designation Category regardless of the insurer’s book/adjusted carrying value.

The Valuation of Securities (E) Task Force adopted this amendment on May 14, 2020

- Updated several technical corrections for policy-based assignments of NAIC Designation Categories – With the introduction of NAIC Designation Categories, the 20 granular delineations of credit risks adopted by the Task Force on Jun. 11, 2018, several policy-based assignments of NAIC Designations did not receive a mapping to an NAIC Designation Category. This amendment identifies the appropriate NAIC Designation Category to be assigned for these policy-based assignments.

The Valuation of Securities (E) Task Force adopted this amendment on Jul. 1, 2020.
- Rename the U.S. Direct Obligations/Full Faith and Credit Exempt List to the NAIC U.S. Government Money Market Fund List and Discontinue the NAIC Bond Fund List – The SVO maintains the NAIC U.S. Direct Obligations/Full Faith and Credit Exempt Money Market Funds List. This list of Money Market Funds (MMF) gets special treatment because they can be reported as a cash equivalent on Schedule E, Part 2. The title of this list has been shortened to “NAIC U.S. Government Money Market Fund List.” This is only a title change to simplify it, no criteria was changed.

The SVO also maintains the NAIC Bond Fund List that contains funds that maintain the highest credit quality rating, maintains the highest market risk rating (this rating type that is no longer assigned), and invests 100% of its total assets in U.S. Government securities along with several other restrictive criteria. No funds qualify for this list and the list has been eliminated.

*The Valuation of Securities (E) Task Force adopted this amendment on Jul. 1, 2020.*

- Permit Supranational Entities Filed with the SVO to be Added to the Sovereign NAIC Designation Equivalent List – The SVO maintains the Sovereign NAIC Designation Equivalent list and publishes it on its webpage ([https://www.naic.org/svo.htm](https://www.naic.org/svo.htm)). Insurers must report supranational entities on the Supplemental Investment Risks Interrogatories (SIRI) with a Sovereign NAIC Designation Equivalent. This amendment permits the SVO to include supranational entities on the Sovereign NAIC Designation Equivalent list if an insurer files a request with the SVO and the SVO is able to determine an appropriate NAIC designation equivalent.

*The Valuation of Securities (E) Task Force adopted this amendment on Aug. 7, 2020.*

- Update to the General Mapping of Credit Rating Provider Ratings, Long and Short-term, to NAIC Designations and NAIC Designation Categories – The Task Force approved an update to the tables reflecting the general mapping of Credit Rating Provider (CRP) ratings to NAIC Designations and NAIC Designation Categories. Short-term investments were mapped to the mid-point of the range of long-term ratings covered by each short-term rating. The update included a note highlighting that the mappings for both long-term and short-term rating symbols are for “Generic Rating Symbols.” CRPs use a variety of symbols; including, combinations of prefixes and suffixes that provide additional information about the rating symbol which are described in the CRP’s documentation. There are over 2,000+ unique rating symbols used by CRPs to describe long-term securities. The SVO webpage ([https://www.naic.org/svo.htm](https://www.naic.org/svo.htm)) maintains a master list of Credit Ratings Eligible for Translation to NAIC Designations.

*The Valuation of Securities (E) Task Force adopted this amendment on Aug. 7, 2020.*
Add Instructions for ETFs that Contain a Combination of Preferred Stocks and Bonds – The Task Force authorized the SVO to review and determine that a fund’s cash flow can be appropriately characterized as fixed income for regulatory purposes, and if so, assign an NAIC Designation to reflect the credit risk associated with the fund’s cash flow and include the name of the fund on the appropriate NAIC List. For inclusion on the SVO-Identified Bond or Preferred Stock ETF list, the ETF must predominantly hold either a portfolio of bonds or preferred stock. This amendment authorizes the SVO to review ETFs that hold both bonds and preferred stock for possible inclusion on the SVO-Identified Preferred Stock ETF list.

*The Valuation of Securities (E) Task Force adopted this amendment on Sep. 29, 2020.*

Update Guidance on Initial and Subsequent Annual Filings, Methodologies and Documentation – The Task Force adopted updated guidance in the P&P Manual for initial and subsequent annual filings and affirmed the SVO’s authority to use reasonable analytical discretion in its assessments including methodologies to utilize and additional documentation or information it may deem necessary for its analysis. The amendment reinforces the Task Force’s expectation that insurance companies will provide the necessary documentation in a timely manner to the SVO and further outlines the types of information the SVO may require. The SVO webpage (https://www.naic.org/svo.htm) also maintains general Guidance on Documentation, Applications and Forms.

*The Valuation of Securities (E) Task Force adopted this amendment on Nov. 18, 2020.*

Revised the Previously Adopted (May 14, 2020) Instructions for Financial Modeled RMBS/CMBS Securities mapping to NAIC Designations to NAIC Designation Categories – The Task Force adopted updated instructions for financially modeled zero-loss RMBS/CMBS securities. The revision eliminates the potential for regulatory capital to be impacted and calibrates the reported NAIC Designation Category for these securities to be consistent with their overall equivalent CRP rating risk level that would be applied under Filing Exemption (FE). Financially modeled zero-loss RMBS/CMBS securities that have the equivalent of an NAIC Designation 1 if the filing exempt process was used and will be mapped to an NAIC Designation NAIC 1 and NAIC Designation Category of NAIC 1.D.

*The Valuation of Securities (E) Task Force adopted this amendment on Dec. 23, 2020.*
 Adopted an updated definition and instructions for Principal Protected Securities – these securities mix a traditional bond or bonds with additional assets that may possess any characteristic. The additional assets are intended to generate an excess return, “performance assets,” and may be any asset, such as derivatives, common stock, commodities, equity indices, etc. The performance assets may include undisclosed assets and are typically not securities that would otherwise be permitted on Schedule D, Part 1 as a bond. The adopted amendment for principal protected securities (PPS) includes an updated description, definition and instructions; it removes these securities from Filing Exemption (FE) eligibility; and requires all PPS, including those currently designated under the FE process, to be submitted to the Securities Valuation Office (SVO) for review under their Subscript S authority beginning January 1, 2021, and filed with the SVO by July 1, 2021, if previously owned.

The Valuation of Securities (E) Task Force adopted this amendment on May 14, 2020

(Note: This change is effective as of Jan. 1, 2021. PPS acquired prior to Jan. 1, 2021 must be filed with the SVO by Jul. 1, 2021, all others follow existing filing guidance.)
adopted by states

letters of credit in support of reinsurance obligations or that are eligible to serve as trustees under various arrangements required by state insurance law. The SVO maintains a list of banks that meet defined eligibility criteria to issue

Reinsurance Agreement Model Regulation

insurance companies for RMBS and CMBS from Price Grids produced by the SSG pursuant to SSAP No. 43R. “…assigned by insurance companies pursuant to the filing exempt rule contained in the Purposes and Procedures Manual or NAIC Designations derived by

specific adoption of the

NAIC

Designations assigned by insurance companies pursuant to the filing exempt rule contained in the Purposes and Procedures Manual or NAIC Designations derived by insurance companies for RMBS and CMBS from Price Grids produced by the SSG pursuant to SSAP No. 43R. “…This standard does not articulate a threshold level for minimum capital and surplus required for insurers to transact business ... Risk-based capital will, however, effectively require minimums when adopted by states.” Accreditation Interlineations - Financial Regulation Standards

5 The SFRS requires the use of the codified version of the Accounting Practices and Procedures Manual. Valuation procedures applicable to long-term invested assets are determined by the nature of the insurer (life or property/casualty) and the NAIC designation assigned to the security by the SVO or SSG; NAIC Designations assigned by insurance companies pursuant to the filing exempt rule contained in the Purposes and Procedures Manual or NAIC Designations derived by insurance companies for RMBS and CMBS from Price Grids produced by the SSG pursuant to SSAP No. 43R. “…To satisfy this standard, ... specific adoption of the NAIC Annual Statement Blank, NAIC Annual Statement Instructions, and the NAIC Accounting Practices and Procedures Manual [is required]. ... Accreditation Interlineations - Financial Regulation Standards

6 The SFRS requires a diversified investment portfolio. Although the Investment of Insurers Model Act (Defined Limits or Defined Standards) is not specifically identified, portions of one or the other model acts have been adopted by many of the states and these relate specific asset allocations to NAIC designations provided by the SVO or in some cases by the SSG; NAIC Designations assigned by insurance companies pursuant to the filing exempt rule contained in the Purposes and Procedures Manual or NAIC Designations derived by insurance companies for RMBS and CMBS from Price Grids produced by the SSG pursuant to SSAP No., 43R. “ ... This standard ... [will require] that statutes, together with related regulations and administrative practices, provide adequate basis ... to prevent, or correct, undue concentration of investment by type and issue and unreasonable mismatching of maturities of assets and liabilities. The standard is not interpreted to require an investment statute that automatically leads to a fully diversified portfolio of investments. Accreditation Interlineations - Financial Regulation Standards

The NAIC Investment of Insurers Model Act (Defined Limits Version) (# 280) imposes a 3% limit on the amount an insurer can invest in a single person (the threshold diversification limit) and also imposes a percentage limit on total investments of a defined credit quality, expressed by reference to NAIC Designation categories (the threshold credit quality limit). An additional percentage limit is then assigned to specific asset categories, which may or may not be subject to adjustment with the two threshold requirements. The limits identified in the Model Act are what would guide portfolio allocation decisions. Once made the insurer would shift to monitoring changes in the portfolio and rebalancing the allocations accordingly. Assuming a process for the identification of concentrations caused by indirect exposures, the insurer would aggregate such exposures with similar risks across all activities.

7 The SFRS requires the adoption of the Credit for Reinsurance Model Act (#785), Credit for Reinsurance Model Regulation (#786) and Life and Health Reinsurance Agreement Model Regulation (#791) or substantially similar laws. The SVO maintains a list of banks that meet defined eligibility criteria to issue letters of credit in support of reinsurance obligations or that are eligible to serve as trustees under various arrangements required by state insurance law.

END NOTES

1 “…The purpose of the Part A: Laws and Regulations standards are to assure that an accredited state has sufficient authority to regulate the solvency of its multi-state domestic insurance industry in an effective manner. … A state may demonstrate compliance with a Part A standard through a law, a regulation, an established practice, which implements the general authority granted to the state or any combination of laws, regulations or practices, which achieves the objective of the standard …” 2014 Accreditation Program Manual. “…For those standards included in the Part A … where the term "substantially similar" is included, a state must have a law, regulation, administrative practice or a combination of the above that addresses the significant elements included in the NAIC model laws or regulations. ... Accreditation Interlineations (Substantially Similar)

20 ...Part B sets out standards required to ensure adequate solvency regulation of multi-state insurers ... In addition to a domestic state’s examination and analysis activities, other checks and balances exist in the regulatory environment. These include ... analyses by NAIC’s staff, ... and to some extent the evaluation by private rating agencies.” 2014 Accreditation Program Manual

4 The SFRS requires the adoption of the Risk Based Capital (RBC) for Insurers Model Act (#312) or a substantially similar law or regulation. RBC factors are tied to NAIC designations assigned by the SVO or in certain cases, for example in the case of Mortgage Referenced Securities, by the SSG; NAIC Designations assigned by insurance companies pursuant to the filing exempt rule contained in the Purposes and Procedures Manual or NAIC Designations derived by insurance companies for RMBS and CMBS from Price Grids produced by the SSG pursuant to SSAP No. 43R. "...This standard does not articulate a threshold level for minimum capital and surplus required for insurers to transact business ... Risk-based capital will, however, effectively require minimums when adopted by states.” Accreditation Interlineations - Financial Regulation Standards

5 The SFRS requires the use of the codified version of the Accounting Practices and Procedures Manual. Valuation procedures applicable to long-term invested assets are determined by the nature of the insurer (life or property/casualty) and the NAIC designation assigned to the security by the SVO or SSG; NAIC Designations assigned by insurance companies pursuant to the filing exempt rule contained in the Purposes and Procedures Manual or NAIC Designations derived by insurance companies for RMBS and CMBS from Price Grids produced by the SSG pursuant to SSAP No. 43R. “...To satisfy this standard, ... specific adoption of the NAIC Annual Statement Blank, NAIC Annual Statement Instructions, and the NAIC Accounting Practices and Procedures Manual [is required]. ... Accreditation Interlineations - Financial Regulation Standards

6 The SFRS requires a diversified investment portfolio. Although the Investment of Insurers Model Act (Defined Limits or Defined Standards) is not specifically identified, portions of one or the other model acts have been adopted by many of the states and these relate specific asset allocations to NAIC designations provided by the SVO or in some cases by the SSG; NAIC Designations assigned by insurance companies pursuant to the filing exempt rule contained in the Purposes and Procedures Manual or NAIC Designations derived by insurance companies for RMBS and CMBS from Price Grids produced by the SSG pursuant to SSAP No., 43R. “ ... This standard ... [will require] that statutes, together with related regulations and administrative practices, provide adequate basis ... to prevent, or correct, undue concentration of investment by type and issue and unreasonable mismatching of maturities of assets and liabilities. The standard is not interpreted to require an investment statute that automatically leads to a fully diversified portfolio of investments. Accreditation Interlineations - Financial Regulation Standards

The NAIC Investment of Insurers Model Act (Defined Limits Version) (# 280) imposes a 3% limit on the amount an insurer can invest in a single person (the threshold diversification limit) and also imposes a percentage limit on total investments of a defined credit quality, expressed by reference to NAIC Designation categories (the threshold credit quality limit). An additional percentage limit is then assigned to specific asset categories, which may or may not be subject to adjustment with the two threshold requirements. The limits identified in the Model Act are what would guide portfolio allocation decisions. Once made the insurer would shift to monitoring changes in the portfolio and rebalancing the allocations accordingly. Assuming a process for the identification of concentrations caused by indirect exposures, the insurer would aggregate such exposures with similar risks across all activities.

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MEMORANDUM

TO: Superintendent Elizabeth Kelleher Dwyer (RI), Chair, Financial Regulations Standards and Accreditation (F) Committee and Director Lori K. Wing-Heier, (AK), Vice Chair, Financial Regulations Standards and Accreditation (F) Committee

FROM: Mike Boerner (TX), Chair, Life Actuarial (A) Task Force,
Pete Weber (OH), Vice Chair, Life Actuarial (A) Task Force

DATE: March 3, 2021


In 2017, the Financial Regulation Standards and Accreditation (F) Committee approved a motion to adopt the Valuation Manual – Effective January 1, 2020 as an accreditation standard. The intention of this memorandum is to update the Committee on changes the Life Actuarial (A) Task Force has made to the Valuation Manual in 2020. The changes were adopted by the Executive (EX) Committee and Plenary at the 2020 Summer Meeting.

Attachment A to this memo includes a detailed listing of the changes made to the Valuation Manual in 2020. On behalf of the Task Force, it is our opinion that none of these items, either individually or collectively, should be considered “significant” as defined by the financial solvency accreditation standards.

As outlined in the Valuation Manual, amendments will be adopted annually by the Executive (EX) Committee and Plenary at each NAIC Summer Meeting. As such, the Valuation Manual will be reposted with an effective date of January 1 of the year following Executive Committee and Plenary adoption. For example, the current Valuation Manual, which encompasses the attached modifications, is titled the 2021 Edition - Valuation Manual. This process allows for an efficient way to update the Valuation Manual and ensures that users have the latest version.

The Task Force sincerely requests that the Committee consider the items listed in Attachment A as “insignificant” changes to the Valuation Manual. We will continue to notify the Committee of any changes to the Valuation Manual and to advise if, in our opinion, those changes are “significant” by financial solvency accreditation standards.
<table>
<thead>
<tr>
<th>LATF VM Amendment</th>
<th>Valuation Manual Reference</th>
<th>Valuation Manual Amendment Proposal Descriptions</th>
<th>LATF Adoption Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019-58</td>
<td>Section A.1</td>
<td>Clarify that prescribed templates are subject to the VM governance requirements for substantive changes</td>
<td>5/21/20</td>
</tr>
<tr>
<td>2019-61</td>
<td>Section II, Subsection 1.D.3</td>
<td>The Life PBR Exemption restriction is intended to apply to ULSG with material secondary guarantees regardless of whether the secondary guarantee is an embedded guarantee or is a separate rider.</td>
<td>2/6/20</td>
</tr>
<tr>
<td>2020-05</td>
<td>VM-20 3.C.4</td>
<td>Clarify that the NPR assumes continuous deaths and immediate payment of claims, and does not apply to surrenders</td>
<td>6/11/20</td>
</tr>
<tr>
<td>2020-07</td>
<td>VM-02 Section 3.A</td>
<td>Remove 4% Floor from Life Standard Nonforfeiture Rate</td>
<td>6/25/20</td>
</tr>
</tbody>
</table>

The individual amendment proposals reside on the Industry tab on the NAIC website and are accessible by following the link below:

LATF Adopted Amendments for the 2021 VM.
MEMORANDUM

TO: Financial Regulation Standards and Accreditation (F) Committee

FROM: NAIC Staff

DATE: March 15, 2021

RE: Part A Preamble Update for the Term and Universal Life Insurance Reserve Financing Model Regulation (#787)

In 2019, the Financial Regulation Standards and Accreditation (F) Committee adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) as a new Part A accreditation standard, effective Sept. 1, 2022, with enforcement to begin Jan. 1, 2023. Model #787 establishes uniform, national standards governing captive reinsurance agreements pertaining to term and universal life insurance policies with secondary guarantees. Prior to Model #787, Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model #830) (AG48) was adopted as an interim step to address concerns regarding such reserve financing transactions. Model #787 completes the XXX/AXXX Reinsurance Framework by codifying the concepts in AG 48.

The NAIC Reinsurance Framework is discussed in the Part A Preamble under the section for captive reinsurers. The current iteration includes reference to the Reinsurance Framework and the impact on compliance with accreditation for captive reinsurers regarding specific lines of business. The lines of business include policies applicable under Section 3 of Model #787, commonly referred to as XXX/AXXX policies. The applicable excerpt of the Preamble is attached and includes recommended tracked changes to reference Model #787. The updates are not considered substantive, but rather are to ensure consistency with the adoption of Model #787 as the new standard for compliance.

Following adoption of AG 48 and prior to the effective date of Model #787, NAIC staff have performed an annual review of all insurers with applicable transactions. The review is designed to ensure all applicable transactions comply with the Reinsurance Framework and, as a result, comply with the Part A accreditation standards. NAIC staff will continue this review until the effective date of Model #787, at which time enactment of the model will be the measure of compliance.
Excerpt from Accreditation Manual – Part A Preamble

Captive Reinsurers
The following Part A standards apply to the regulation of a state’s domestic insurers licensed and/or organized under its captive or special purpose vehicle statutes or any other similar statutory construct (captive insurer) that reinsurance business covering risks residing in at least two states, but only with respect to the following lines of business:

1) Term and universal life with secondary guarantee policies that are applicable under Section 3 of the Term and Universal Life Insurance Reserve Financing Model Regulation (#787)(commonly referred to as XXX/AXXX policies). The application of this provision is intended to have a prospective-only effect, so that regulation of captive insurers, special purpose vehicles and any other entities that reinsurance these types of policies will not be subject to the Part A standards if the policies assumed were both (1) issued prior to Jan. 1, 2015, and (2) ceded so that they were part of a reinsurance arrangement as of Dec. 31, 2014. [Drafting Note: This paragraph of the Preamble became effective Jan. 1, 2016]

2) Variable annuities valued under Actuarial Guideline XLIII—CARVM for Variable Annuities (AG 43). [Drafting Note: This paragraph of the Preamble is not yet effective. Effective date for compliance to be determined.]

3) Long term care insurance valued under the Health Insurance Reserves Model Regulation (Model #10). [Drafting Note: This paragraph of the Preamble is not yet effective. Effective date for compliance to be determined.]

With regard to a captive insurer, special purpose vehicle, or any other entity assuming XXX/AXXX business, regulation of the entity is deemed to satisfy the Part A accreditation requirements if the applicable reinsurance transaction complies with Model #787.

[Drafting Note: The Part A standards with respect to entities assuming variable annuities and long term care reinsurance business are intended to be effective with respect to both currently in-force and future business. However, the effective dates for variable annuities and long term care insurance are not yet determined, and their application to in-force business need further discussion].
MEMORANDUM

To: Financial Regulation Standards and Accreditation (F) Committee

From: Financial Condition (E) Committee

Date: March 8, 2021

Re: 2020 Revisions to Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)

On Dec. 9, 2020, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). These revisions implemented a Group Capital Calculation (GCC) for the purpose of group solvency supervision and Liquidity Stress Test (LST) for macroprudential surveillance.

Please find attached, memorandums and proposed changes to the Accreditation (E) Committee as adopted by the Financial Condition (E) Committee related to these most recent changes to #440 and #450. Each of the memorandum’s summarize the basis for recommending that certain provisions of these model changes become part of the Accreditation program as well as suggested timing. With respect to timing, consistent with action taken by the Financial Regulation Standards and Accreditation (F) Committee to use an expedited process in 2019 with respect to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) due to the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement), we recommend a similar expedited process with respect to states who are a Group Wide Supervisor of a group with operations in the EU or UK. The attached provide further details on the specifics of such recommendations.
MEMORANDUM

To: Financial Condition (E) Committee

From: Group Capital Calculation (E) Working Group

Date: February 25, 2021

Re: 2020 Revisions to Insurance Holding Company System Regulatory Model Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)

Executive Summary

On Dec. 9, 2020, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). These revisions implemented a Group Capital Calculation (GCC) for the purpose of group solvency supervision and Liquidity Stress Test (LST) for macroprudential surveillance. This memorandum makes recommendations with respect to the accreditation standards that this Working Group believes is appropriate with respect to only the GCC and expect the Financial Stability (EX) Task Force to make separate recommendations to the Committee with respect to the LST.

The GCC was developed as a result of discussions which began in 2015. The GCC is a natural extension of work state insurance regulators had begun, in part by lessons learned from the most recent financial crisis, to better understand an insurance group’s financial risk profile for the purpose of enhancing policyholder protections. While state insurance regulators currently have the authority to obtain information regarding the capital positions of non-insurance affiliates, they do not have a consistent analytical framework for evaluating such information. The GCC is designed to address this shortcoming and will serve as an additional financial metric that will assist state insurance regulators in identifying risks that may emanate from a holding company system. The GCC, and related financial reporting, will provide comprehensive transparency to state insurance regulators, making risks more easily identifiable and quantifiable. For these reasons, the Working Group recommends adoption of #440 and #450 as accreditation standards for all states with the normal accreditation timeline, which would result in an effective date of January 1, 2026.

In addition, the GCC is intended to comply with the requirements under the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement), which was signed on Sept. 22, 2017. On Dec. 18, 2018, a similar Covered Agreement was signed with the United Kingdom (UK). The GCC is intended to meet the requirement that the states have a “worldwide group capital calculation” in place by Nov. 7, 2022 in order to avoid the EU from imposing a group capital assessment or requirement at the level of the worldwide parent undertaking. Failure of any state to do so for any U.S. group operating in such jurisdiction raises the potential for any supervisor in the EU or UK to impose its
own group capital calculation (e.g., Solvency II capital requirements) on that group and therefore all of the U.S. insurers within that group. Due to this agreement, the Working Group recommends that the accreditation standard become effective Nov. 7, 2022 for those states who are the Group Wide Supervisor of a group with operations in the EU or UK.

**A statement and explanation of how the potential standard is directly related to solvency surveillance and why the proposal should be included in the standards:**

The current Insurance Holding Company Systems accreditation standard requires that state law shall contain the significant elements from Model #440 and Model #450. These models have provided state insurance departments the framework for insurance group supervision since the early 1970s. Following the 2008 financial crisis, state regulators identified group supervision as an area where improvements could be made to the U.S. system. In December 2010, the NAIC adopted changes to the models enhancing the domestic legal structure under which holding companies are supervised. In December 2014, the NAIC adopted revisions to clarify legal authority and powers to act as a group-wide supervisor for internationally active insurance groups. These changes are newly required elements of the NAIC Accreditation Program and have been satisfactorily adopted by nearly all accredited U.S. jurisdictions. As discussed in the preceding paragraphs, the GCC was designed to enhance these same standards that were previously included as accreditation standards.

**A statement as to why ultimate adoption by every jurisdiction may be desirable:**

The Group Capital Calculation (E) Working Group believes that all states that are the lead state for a group subject to the GCC should be required to adopt the model revisions. The GCC is a tool intended to help protect the policyholders in all states from the risk that can emanate from outside the domestic insurer and will be an input into the Group Profile Summary (GPS). After an initial filing by all insurance groups, the GCC is required for all U.S. insurance groups with greater than $1 billion in premium. The groups subject to the GCC are expected to have domestic insurers in most U.S. states. Therefore, it is recommended that that the new significant elements apply to all states.

**A statement as to the number of jurisdictions that have adopted and implemented the proposal or a similar proposal and their experience to date:**

We are not currently aware of any states that have adopted the 2020 revisions to Model #440 and Model #450, although we have been advised that many states have begun their legislative processes for adoption of these revisions.

**A statement as to the provisions needed to meet the minimum requirements of the standard. That is, whether a state would be required to have “substantially similar” language or rather a regulatory framework. If it is being proposed that “substantially similar” language be required, the referring committee, task force or working group shall recommend those items that should be considered significant elements:**

The current accreditation standard for Model #440 and Model #450 requires state adoption on a substantially similar basis. Therefore, the Group Capital Calculation (E) Working Group supports the attached proposed significant elements (Attachment A) be adopted by NAIC-accredited jurisdictions in a “substantially similar” manner, as that term is defined in the Accreditation Interlineations of the NAIC Financial Regulation Standards and Accreditation Program. The Financial Regulation Standards and Accreditation (F) Committee should consider a waiver of procedure as provided for in the Accreditation Program Manual and expeditiously consider adoption of this
standard. The Group Capital Calculation (E) Working Group recommends that the accreditation standard become effective Nov. 7, 2022, the end of the 60-month period contemplated under the Covered Agreement, with enforcement of the standard to commence Jan. 1, 2023. However, the Working Group is also supportive of the effective date being bifurcated to allow those states that are not the Group Wide Supervisor of a group with operations in the EU or UK to be subject to a later effective date in line with the normal accreditation timeline, which would result in an effective date of January 1, 2026.

There were also revisions made to Section 8 of Model #440 regarding Confidential Treatment. The Group Capital Calculation (E) Working Group strongly supports the use of language similar to that contained in Section 8G of Model #440. This language was considered very critical to the GCC as its very important that members of the insurance industry (or regulators) not be allowed to make the results of the GCC public in any way as they are designed as regulatory-only tools. Unlike RBC that has regulatory trigger points, the GCC does not, and the regulators of these groups believed it would be detrimental if these tools were used by insurers as a means to advertise their relative solvency strength.

**An estimate of the cost for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it, if reasonably quantifiable:**

The NAIC has not performed a cost/benefit analysis with respect to the 2020 revisions to Model #440 and Model #450, nor do we believe that the specific costs for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it are reasonably quantifiable. However, the possible exemptions allowed under Model #450 are specifically designed to consider the cost to complete the GCC by the insurance company and the benefits of the GCC to the lead-state commissioner. More specifically, all insurers are required to submit the GCC at least once, after which time the expectation is that the lead state commissioner will evaluate the added insight brought to the state from GCC; then, provided the group has premium less than $1 billion, no international business, no risky non-regulated entities and no banks or similar capital regulated entities in the group, the lead state commissioner can exempt the group from filing in the future.

In addition, the construction of the GCC also considers cost of completion and specifically provides a principle-based approach where the insurance company can exclude non-risky affiliates from the calculation and also provides the insurance company to group the information of multiple non-insurance/non-regulated affiliates as a means to further reduce the burden of completion. In short, the GCC is only as complex as the insurance group has structured itself, and therefore the GCC already inherently considers the cost to comply.
6. Insurance Holding Company Systems

State law should contain the NAIC Insurance Holding Company System Regulatory Act (#440), or an act substantially similar, and the department should have adopted the NAIC Insurance Holding Company System Model Regulation (#450).

Insurance Holding Company Systems – continued

Changes to Existing

k. Filing requirements for the enterprise risk filing similar to those specified in Section 4L(1) of the Model #440?

New

l. Filing requirements for the group capital calculation filing similar to those specified in Section 4L(2) of Model #440?

i. The ultimate controlling person of every insurer subject to registration shall annually file a group capital calculation completed in accordance with the NAIC Group Capital Calculation Instructions as directed by the lead state commissioner similar to section 4L(2)?

ii. Provision for exempting an insurance holding company system that has only one insurer within its holding company structure, that only writes business [and is only licensed] in its domestic state and assumes no business from any other insurer, similar to 4L(2)(a)?

iii. Provision for exempting an insurance holding company system that is required to perform a group capital calculation specified by the U.S. Federal Reserve? If the Federal Reserve Board cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the GCC, similar to 4L(2)(b)?

iv. Provision for exempting an insurance holding company system whose non-U.S. group-wide supervisor is located within a Reciprocal Jurisdiction that recognizes the U.S. state regulatory approach to group supervision and group capital, similar to 4L(2)(c)?

v. Provision for exempting an insurance holding company system that provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program and whose non-U.S. group-wide supervisor that is not in a Reciprocal Jurisdiction recognizes and accepts the GCC as the worldwide group capital assessment for U.S. insurance groups who operate in that jurisdiction, similar to 4L(2)(d)?

vi. Provision that gives the lead state the authority to require the GCC for U.S. operations of any non-U.S. based insurance holding company system where after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes, similar to 4L(2)(e)?

Changes to Existing

cc. Provisions for protecting confidential information submitted to the commissioner, including provisions maintaining confidentiality for information shared with state, federal and international regulators similar to Section 8? If sharing confidential information with the NAIC and third-party consultants is permitted, appropriate confidentiality protections should be included.

New

m. Provision prohibiting the making, publishing, disseminating, circulating or placing before the public in any way the group capital calculation and resulting group capital ratio under Section 4L(2) and/or the liquidity stress test along with its results and supporting disclosures required under Section 4L(3), by any insurer, broker, or other person engaged in any manner of the insurance business, except if the sole purpose of the announcement is to rebut a materially false statement, similar to Section 8G of Model #440?

n. Filing requirements for the group capital calculation filing similar to those specified in Section 21 of Model #450?
i. Provision that gives the lead state the authority to exempt the filing of the group capital calculation provided the criteria are similar to those allowed under Section 21A of Model #450?

ii. Provision that gives the lead state the authority to accept a limited group capital filing provided the criteria are similar to those allowed under Section 21B of Model #450?

iii. Provision that gives the lead state the authority to require the group capital calculation of any group that previously met an exemption or submitted a limited filing if any insurer in the holding company system either triggers an RBC action level event, is deemed in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer, similar to those allowed under Section 21C of Model #450?

iv. Provision that sets forth the criteria for a jurisdiction to be included on the NAIC listing that “recognize and accept the group capital calculation” similar to that required under Section 21D and Section 21E of Model #450?
MEMORANDUM

To: Financial Condition (E) Committee
From: Financial Stability (E) Task Force
Date: February 22, 2021
Re: 2020 Revisions to Insurance Holding Company System Regulatory Act (#440)

Executive Summary

On Dec. 9, 2020, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). These revisions implemented a Group Capital Calculation (GCC) for the purpose of group solvency supervision and Liquidity Stress Test (LST) for macroprudential surveillance. This memorandum makes recommendations with respect to the accreditation standards that this Task Force believes is appropriate with respect to only the LST and expect the Group Capital Calculation (E) Working Group to make separate recommendations to the Committee with respect to the GCC.

Post-financial crisis, regulators from all financial sectors across the globe recognized the need for macroprudential surveillance and tools to address macroprudential risks. While the solvency framework established and managed by the Financial Condition (E) Committee thoroughly addresses legal entity insurers and insurance groups, there was no group with a macroprudential scope. This Task Force was created to fill this gap, and in 2017 was charged to “analyze existing post-financial crisis regulatory reforms for their application in identifying macroprudential trends, including identifying possible areas of improvement or gaps, and propose . . . enhancements and/or additions to further improve the ability of state insurance regulators and industry to address macroprudential impacts.” The Task Force created the NAIC Macroprudential Initiative (MPI) to focus its efforts in four key areas: liquidity risk, recovery and resolution, capital stress testing, and exposure concentrations. Liquidity risk was consistently recognized as a key macroprudential risk by federal and international regulatory agencies, and there were several attempts to assess potential market impacts emanating from a liquidity stress in the insurance sector. Many of these analyses relied heavily on anecdotal assumptions and observations from behaviors of other financial sectors.

In order to provide more evidence-based analyses, the Task Force decided to develop a LST for large life insurers that would aim to capture the impact on the broader financial markets of aggregate asset sales under a liquidity stress event. Unlike capital adequacy, which has risk-based capital as a standardized legal entity capital assessment tool and the newly created Group Capital Calculation to provide a capital analysis tool at the group level, there is no regulatory liquidity assessment or stress tool. The Task Force focused on large life insurers due to the long-term cash buildup involved in many life insurance contracts and the potential for large scale liquidation of assets, not because liquidity risk does not exist in other insurance segments. Thus, the primary goal of the LST is to provide...
quantitative as well as qualitative insights for macroprudential surveillance, such as identifying the amount of asset sales that could occur during a specific stress scenario; but it will also aid micro prudential regulation as well. Because this stress testing is complex and resource-intensive, a set of scope criteria were developed to identify life insurers with large balances of activities assumed to be highly correlated with liquidity risk; thus, many life insurers will not be subject to the LST.

A statement and explanation of how the potential standard is directly related to solvency surveillance and why the proposal should be included in the standards:

The current Insurance Holding Company Systems accreditation standard requires that state law shall contain the significant elements from Model #440 and Model #450. These models have provided state insurance departments the framework for insurance group supervision since the early 1970s. Following the 2008 financial crisis, state regulators identified group supervision as an area where improvements could be made to the U.S. system. In December 2010, the NAIC adopted changes to the models enhancing the domestic legal structure under which holding companies are supervised. In December 2014, the NAIC adopted revisions to clarify legal authority and powers to act as a group-wide supervisor for internationally active insurance groups. These changes are newly required elements of the NAIC Accreditation Program and have been satisfactorily adopted by nearly all accredited U.S. jurisdictions. As discussed in the preceding paragraphs, the LST was designed to enhance these same standards that were previously included as accreditation standards.

Macroprudential risks can directly impact regulated legal entity insurers and groups, and/or can emanate from or be amplified by these insurers and transmitted externally. The NAIC solvency surveillance framework must address macroprudential risks to ensure that the companies states regulate remain financially strong for the protection of policyholders, while serving as a stabilizing force to contribute to financial stability, including in stressed financial markets. The LST is the first new tool developed for the macroprudential program within the financial solvency framework.

A statement as to why ultimate adoption by every jurisdiction may be desirable:

The Financial Stability Task Force believes that all states that are the lead state for a group subject to the LST should be required to adopt the model revisions. The LST is a tool intended to help assess the impacts the life insurance industry can have on the broader financial markets in a time of stress. Ideally, the tool would have been required of all life insurance groups, but this was not possible due to the complexity and resources required to accomplish such liquidity stress testing. Thus, the LST uses a set of scope criteria to identify those life insurers with significant amounts in activities assumed to have high liquidity risk, thus representing the larger portion of the life insurance industry in terms of liquidity risk rather than representing the entire life insurance industry. If a scoped-in life insurance group was not subject to the LST because a state did not adopt the model revisions, this would significantly reduce the ability of the NAIC to represent the results as truly macroprudential and reflective of the majority of risks of the life insurance sector. Additionally, the LST results will be helpful to the lead states in their group supervision efforts as well.

Though not every state will be the lead state of a scoped-in group, the Task Force still believes the model revisions for the LST should be adopted in every state. It is fairly common for legal entity insurers to move from one group to another, impacting the group dynamics including the lead state determination, and each state should have the LST in their statutes to ensure they will be prepared for any future appointment as lead state. Also, even without legal entities changing groups, business acquisition and operational changes within existing groups might subject a previously excluded group to the LST. Therefore, it is recommended that that the new significant elements apply to all states.
A statement as to the number of jurisdictions that have adopted and implemented the proposal or a similar proposal and their experience to date:

We are not currently aware of any states that have adopted the 2020 revisions to Model #440, although we have been advised that many states have begun their legislative processes for adoption of these revisions.

A statement as to the provisions needed to meet the minimum requirements of the standard. That is, whether a state would be required to have “substantially similar” language or rather a regulatory framework. If it is being proposed that “substantially similar” language be required, the referring committee, task force or working group shall recommend those items that should be considered significant elements:

The current accreditation standard for Model #440 and Model #450 requires state adoption on a substantially similar basis. Therefore, the Financial Stability (E) Task Force supports the attached proposed significant elements (Attached) be adopted by NAIC-accredited jurisdictions in a “substantially similar” manner, as that term is defined in the Accreditation Interlineations of the NAIC Financial Regulation Standards and Accreditation Program. The Financial Regulation Standards and Accreditation (F) Committee should consider a waiver of procedure as provided for in the Accreditation Program Manual and expeditiously consider adoption of this standard. The Financial Stability (E) Task Force recommends that the accreditation standard become effective Nov. 7, 2022, concurrent with the Group Capital Calculation revisions to the model, with enforcement of the standard to commence Jan. 1, 2023.

There were also revisions made to Section 8 of Model #440 regarding Confidential Treatment. The Financial Stability (E) Task Force strongly supports the use of language similar to that contained in Section 8G of Model #440. This language was considered very critical to the LST as its very important that members of the insurance industry (or regulators) not be allowed to make the results of the LST public in any way as they are designed as regulatory-only tools using complex assumptions for potential future stress events and the results could easily be misinterpreted and misrepresented by other users, causing true financial harm to the insurers.

An estimate of the cost for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it, if reasonably quantifiable:

The NAIC has not performed a cost/benefit analysis with respect to the 2020 revisions to Model #440, nor do we believe that the specific costs for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it are reasonably quantifiable. However, the LST scope criteria selects the larger, more complex life insurers, and all of these already perform some form of internal liquidity stress tests. While there are regulatory requirements for inputs and outputs, truly significant costs are avoided by using their existing internal stress testing systems instead of specifying a regulatory model.
6. Insurance Holding Company Systems

State law should contain the NAIC Insurance Holding Company System Regulatory Act (#440), or an act substantially similar.

**Changes to Existing**

k. Additions to the filing requirements for the enterprise risk filing specified in Section 4L(1) of the Model #440 (see next item).

**New**

C. Define “NAIC Liquidity Stress Test Framework” similar to that in Section 1K?

d. Define “Scope Criteria” similar to that in Section 1M?

**Changes to Existing**

l. Filing requirements for the liquidity stress test filing similar to those specified in Section 4L(3) of Model #440:

i. The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC Liquidity Stress Test Framework shall file the results of a specific year’s Liquidity Stress Test to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook similar to Section 4L(3)?

ii. Insurers meeting at least one threshold of the Scope Criteria for a specific data year are scoped into that year’s NAIC Liquidity Stress Test Framework unless the lead state, after consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should not be scoped into the Framework for that data year similar to Section 4L(3)(a)? Insurers that do not trigger at least one threshold of the Scope Criteria are considered scoped out of the NAIC Liquidity Stress Test Framework for the specified data year, unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should be scoped into the Framework for that data year?

iii. Provision requiring compliance with the NAIC Liquidity Stress Test Framework’s instructions and reporting templates for the specific data year and any lead state insurance commissioner determinations in consultation with the Financial Stability Task Force or its successor, provided within the Framework similar to Section 4L(3)(b)?

cc. Provisions for protecting confidential information submitted to the commissioner, including provisions maintaining confidentiality for information shared with state, federal and international regulators similar to Section 8? If sharing confidential information with the NAIC and third-party consultants is permitted, appropriate confidentiality protections should be included.

m. Provision prohibiting the making, publishing, disseminating, circulating or placing before the public in any way the group capital calculation and resulting group capital ratio under Section 4L(2) and/or the liquidity stress test along with its results and supporting disclosures required under Section 4L(3), by any insurer, broker, or other person engaged in any manner of the insurance business, except if the sole purpose of the announcement is to rebut a materially false statement, similar to Section 8G of Model #440?
INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

International Insurance Relations (G) Committee April 7, 2021, Minutes ......................................................... 12-2
International Insurance Relations (G) Committee March 25, 2021, Minutes (Attachment One) .......................... 12-5
   International Association of Insurance Supervisors (IAIS) Draft Application Paper on the Supervision of
   Control Functions – NAIC Approved Comments (Attachment One-A) ......................................................... 12-6
International Insurance Relations (G) Committee Feb. 3, 2021, Minutes (Attachment Two) .............................. 12-8
   IAIS Draft Application Paper on Resolution and Consultation on Liquidity Metrics – NAIC Approved
   Comments (Attachment Two-A) ................................................................................................................... 12-10
   Travelers Comments on NAIC Comments on IAIS Draft Application Paper on Resolution and Consultation
   on Liquidity Metrics (Attachment Two-B) ..................................................................................................... 12-15
International Insurance Relations (G) Committee Jan. 6, 2021, Minutes (Attachment Three) ......................... 12-17
   Joint Sustainable Insurance Forum (SIF) – IAIS Draft Application Paper on the Supervision of Climate-
   Related Risks in the Insurance Sector – NAIC Approved Comments (Attachment Three-A) ......................... 12-18
American Academy of Actuaries (Academy) Presentation on Scalar Methodologies (Attachment Four) ......... 12-19
The International Insurance Relations (G) Committee met April 7, 2021. The following Committee members participated: Gary D. Anderson, Chair (MA); Bruce R. Ramge, Vice Chair (NE); Evan G. Daniels (AZ); Andrew N. Mais (CT); Karima M. Woods (DC); David Altmaier (FL); Doug Ommen (IA); James J. Donelon (LA); Kathleen A. Birrane (MD); Anita G. Fox (MI); Chlora Lindley-Myers (MO); Marlene Caride (NJ); Andrew R. Stolfi (OR); Jessica K. Altman (PA); and Raymond G. Farmer (SC).

1. **Adopted its March 25, 2021; Feb. 3, 2021; Jan. 6, 2021; and 2020 Fall National Meeting Minutes**

   The Committee met March 25, 2021; Feb. 3, 2021; Jan. 6, 2021; and Dec. 9, 2020, and took the following action: 1) approved submission of NAIC comments on the International Association of Insurance Supervisors’ (IAIS) draft *Application Paper of Supervision of Control Functions, Application Paper of Resolution Powers and Planning, and Consultation on the Development of Liquidity Metrics*; 2) approved submission of NAIC comments on the joint Sustainable Insurance Forum (SIF) and IAIS draft *Application Paper on the Supervision of Climate-Related Risks in the Insurance Sector*; 3) heard an update on upcoming IAIS committee meetings and activities; and 4) heard an update on the SIF, Organisation for Economic Co-operation and Development (OECD), and other supervisory cooperation activities.

   Commissioner Anderson noted that the Committee also met Feb. 16 in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss strategy and planning related to international issues, bilateral and regional outreach, and member educational efforts over the course of 2021.

   Commissioner Caride made a motion, seconded by Commissioner Mais, to adopt the Committee’s March 25, 2021 (Attachment One), Feb. 3, 2021 (Attachment Two), Jan. 6, 2021 (Attachment Three) and Dec. 9, 2020 (see NAIC Proceedings – Fall 2020, International Insurance Relations (G) Committee) minutes. The motion passed unanimously.

2. **Heard an Update on Key 2021 Projects and Priorities of the IAIS**

   Commissioner Anderson reported on recent IAIS activities, starting with an overview of the first set of committee meetings in 2021 that took place in March. Regarding implementation assessment activities related to the holistic framework for systemic risk, the first-phase baseline assessment (BLA) report has been finalized, and the second-phase targeted jurisdictional assessment is now underway. He then provided an update on the insurance capital standard (ICS) monitoring period, noting that IAIS members: 1) discussed results of the 2020 data collection; 2) received an update on the aggregation method (AM); and 3) discussed the public consultation comments received on the draft definition and high-level principles and the plan to develop criteria to assess whether the AM provides comparable outcomes to the ICS. Development of the criteria will take place throughout 2021, with a consultation expected by year-end.

   Commissioner Anderson said another important area of work underway are strategic discussions on the IAIS role, activities and priorities related to climate risk and sustainability. Lastly, he said the IAIS will also continue to monitor the ongoing global impact of COVID-19 on supervisors and the insurance sector.

   Conor Donaldson (IAIS) added that with respect to the BLA, the internal IAIS report has been uploaded for members, and a public version of the report is expected to be published in the next month. He said the IAIS expects to publish its Application Paper on climate risk before its June committee meetings. Mr. Donaldson noted continued work on Multilateral Memorandums of Understanding (MMoU) as an essential tool to enable supervisory cooperation, and the importance of having a strong chair from the NAIC for the work. The IAIS recently welcomed Argentina as its latest MMoU signatory.

   Steve Broadie (American Property Casualty Insurance Association—APCIA) asked about IAIS plans to publish a final version of the high-level principles for assessment of AM comparability and the IAIS’ resolution of comments from the public consultation. Ryan Workman (NAIC) noted that the IAIS is in the process of drafting a thematic high-level summary of comments received, which will be made public once finished.

   Commissioner Anderson thanked interested parties for their comments and encouraged them to attend the IAIS Secretariat question-and-answer (Q&A) session following the Committee meeting.
3. Heard a Presentation on Scalar Methodologies from the Academy

Steve Jackson (American Academy of Actuaries—Academy) gave an update on the Academy’s work looking at scalar methodologies, the proposal for which was presented to the Committee at the NAIC’s 2020 Summer National Meeting. He noted that the Executive Summary has been released for the Academy’s paper, *Aggregating Regulatory Capital Requirements Across Jurisdictions: Theoretical and Practical Considerations* (Attachment Four), and he presented the main findings and conclusions of the paper. Mr. Jackson noted that the full paper would be made available in the coming days.

Commissioner Anderson thanked the Academy for its efforts and asked whether there were any surprises or challenges during the work looking at scalars. Mr. Jackson noted that the whole project was more challenging than originally expected and that one surprise is that the probability of negative outcomes methodology appears to be more plausible than expected.

4. Heard an Update on International Activities

a. Regional Supervisory Cooperation

Director Ramge reported that following the success of last fall’s International Fellows Program, the NAIC will once again offer the program in a fully virtual format this spring, April 19–23. He said while there is no substitute for the hands-on experience that fellows receive during the weeks they spend hosted by state insurance departments and meeting with NAIC staff, the NAIC is grateful to be able to offer international colleagues an opportunity for technical growth and relationship building virtually. Director Ramge noted more than 100 participants are set to join from most major regions, including Western and Eastern Europe, Latin America, the Caribbean, Asia, Africa, and the Middle East.

Director Ramge said the NAIC met virtually on Dec. 10, 2020, with the Financial Services Agency (FSA) of Japan for a biannual bilateral dialogue. The NAIC and FSA discussed various regulatory and supervisory topics and developments, including: responses to COVID-19; updates on 2020 initiatives; and a preview of priorities for 2021.

Director Ramge said the NAIC held a virtual bilateral dialogue with representatives from the European Insurance and Occupational Pensions Association (EIOPA) and European Union (EU) member states on Dec. 18, 2020. He said NAIC representatives provided updates on a variety of initiatives, including: race and insurance, climate and resilience, the Macroprudential Initiative, the group capital calculation (GCC), and responses to COVID-19. Ongoing dialogue and discussions through the EU-U.S. Insurance Dialogue Project and its various workstreams has also continued.

Director Ramge reported that Dean L. Cameron, Director of the Idaho Department of Insurance (DOI) and NAIC President-Elect, participated in the 7th Annual Casablanca Insurance Meeting, organized in part by the Moroccan Supervisory Authority of Insurance and Welfare, with whom the NAIC has as a memorandum of understanding. He explained that Director Cameron spoke on a panel focused on changes necessary to foster innovation and inclusivity within insurance, noting the NAIC’s commitment to supporting the creation of innovative products, the importance of consumer education, and the continued work of the NAIC’s Special (EX) Committee on Race and Insurance.

Director Ramge said the Financial Stability Institute (FSI), the Association of Insurance Supervisors of Latin American and the IAIS will hold a joint webinar this month providing a platform for several Latin American authorities to exchange views on the main insurance risks that currently concern supervisors in the region. He noted that Nina Chen, Chief Sustainability Officer for the New York Department of Financial Services (DFS), will represent the NAIC on a panel on the supervisor’s role in addressing risks from climate change.

Director Ramge noted that a virtual bilateral meeting with the Bermuda Monetary Authority (BMA) is set to take place later this month, which will build on previous meetings and include discussions on the ICS and other timely topics.

Director Ramge said that with the United Kingdom’s (UK’s) exit from the EU, the NAIC is beginning to establish a closer working relationship with the Bank of England’s Prudential Regulation Authority (PRA) and the Financial Conduct Authority (FCA). Discussions have begun regarding the creation of recurring bilateral discussions, with the first expected to take place later this summer.

b. OECD

Director Ramge reported the OECD’s Insurance and Private Pensions Committee (IPPC) held a two-day virtual event in later March on addressing the protection gap for pandemic risk. Director Ramge highlighted topics of focus during the virtual event and noted the importance of collaboration and cooperation in the insurance sector.
meeting, including: 1) research showing how COVID-19 highlighted important coverage gaps for pandemic risk; 2) research showing that the magnitude of potential losses and high levels of correlation make pandemic risk challenging to insure; and 3) conclusions on loss-sharing arrangements between governments and insurers/reinsurers for future pandemics. Director Ramge noted the OECD’s Environment Directorate is organizing a virtual workshop for regulators on reducing and managing the risk of losses and damages from climate change, and that the next meeting of the IPPC will be held virtually in mid-June.

c. **SIF**

Director Ramge said the NAIC, alongside individual state SIF members—California, New York and Washington—participated in the first virtual call of 2021 in March. He noted that the SIF has a new chair, Anna Sweeney from the Bank of England, and that the Federal Insurance Office (FIO) also recently joined the SIF. The meeting included discussions on the start of the three workstreams agreed to in the SIF’s work plan: 1) impacts of climate-related risks on insurability of assets; 2) broader sustainability issues beyond climate; and 3) climate risks in the actuarial processes.

5. **Discussed Other Matters**

Commissioner Anderson noted that the NAIC’s 2021 International Insurance Forum will take place virtually and be livestreamed May 25–26, with morning and afternoon sessions. He said the Committee’s next meeting is scheduled for May 5 to review and approve the submission of NAIC comments on the IAIS draft *Application Paper on Macroprudential Supervision*.

Robert Neill (American Council of Life Insurers—ACLI) noted that ACLI President Susan Neely will be participating in a panel at the NAIC’s International Insurance Forum. He offered the ACLI’s assistance to continue to engage in constructive dialogue on work related to liquidity metrics. Lastly, he noted climate risk as a top issue being addressed domestically and internationally, and said that the Financial Stability Oversight Council is looking at these issues as well. As work continues by federal agencies and the states on such matters, the ACLI welcomes constructive discussions with the inclusion of its members to avoid any redundancies.

Having no further business, the International Insurance Relations (G) Committee adjourned.
International Insurance Relations (G) Committee
Virtual Meeting
March 25, 2021

The International Insurance Relations (G) Committee met March 25, 2021. The following Committee members participated:
Gary D. Anderson, Chair (MA); Bruce R. Ramge, Vice Chair (NE); Evan G. Daniels (AZ); Andrew N. Mais (CT); Karima M. Woods (DC); David Altmaier (FL); Doug Ommen (IA); James J. Donelon (LA); Kathleen A. Birrane (MD); Anita G. Fox (MI); Chlora Lindley-Myers (MO); Marlene Caride (NJ); Andrew R. Stolfi (OR); Jessica K. Altman (PA); and Raymond G. Farmer (SC).

1. **Discussed NAIC Comments on the IAIS Draft Application Paper on Supervision of Control Functions**

Commissioner Anderson explained that the International Association of Insurance Supervisors (IAIS) draft Application Paper on Supervision of Control Functions aims to help supervisors address issues related to the supervision of control functions as described in Insurance Core Principles (ICPs) and the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame)—in particular, material from ICP 8 (Risk Management and Control Functions), but also relevant to ICP 5 (Suitability of Persons) and ICP 7 (Corporate Governance).

Ryan Workman (NAIC) gave an overview of the NAIC’s comments on the draft application paper, noting that some were editorial or for clarification. He provided more detail on those comments that were more substantial.

David Snyder (American Property Casualty Insurance Association—APCIA) noted agreement with the NAIC comments and said that the APCIA will submit their own comments. He stated that overall insurer corporate governance and insurance regulation has shown the stability of the sector throughout multiple crises. He commented that it is important that the application paper: 1) recognize the notion of proportionality; 2) reflect that the way insurance groups can effectively organize their control functions may vary based on the business model of the group; and 3) appropriately characterize the role of the supervisor when it comes to insurer governance areas such as renumeration, outsourcing, attendance at board meetings and succession planning.

Commissioner Caride made a motion, seconded by Director Farmer, to approve submission of the NAIC comments (Attachment One-A). The motion passed.

Having no further business, the International Insurance Relations (G) Committee adjourned.

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<table>
<thead>
<tr>
<th>Section/Paragraph</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Typo: The work performed by control functions...</td>
</tr>
<tr>
<td>10</td>
<td>At the end of the paragraph, it is not clear what 'need' is being referred to. To add to the checks and balances and provide assurances to the Board or to have the control functions covered in ICP? Suggest clarifying.</td>
</tr>
<tr>
<td>11</td>
<td>Regardless of the organisational model adopted...</td>
</tr>
<tr>
<td>13</td>
<td>Should use a comma rather than semicolon: There was a consistent view among survey participants that actuaries developing products and setting prices... and actuaries assessing the adequacy of technical provisions for those products, should be independent from each other.</td>
</tr>
<tr>
<td>21</td>
<td>This paragraph does not really address independence and could provide a better introduction to points covered by the rest of the section (similar to what para 35 does); suggest: The central role of control functions and their level of independence may be adversely impacted depending how these functions are considered, established, and positioned in the reporting structure within the insurer. Additionally, remuneration practices and processes for dealing with conflicts of interest may affect the independence of control functions. In this regard, the supervisor should assess how well an insurer's control functions align with good practices and are compliant with governance requirements.</td>
</tr>
<tr>
<td>25</td>
<td>Suggest revising the start of the paragraph to better reflect that the bullets are examples and not the only indicators: There may be a variety of signs that the independence of an insurer's control functions may be compromised, such as...</td>
</tr>
<tr>
<td>28</td>
<td>It is not clear what 'weak status' refers to – lacking independence or weak stature or both? Suggest using terminology used elsewhere in the paper may make this clearer.</td>
</tr>
<tr>
<td>41</td>
<td>Typo: most supervisors responded that they use a combination of methods...</td>
</tr>
<tr>
<td>42</td>
<td>Second bullet should control function be plural? Or both: Periodic review of the control function(s)...</td>
</tr>
<tr>
<td>58</td>
<td>There may be a variety of the following indicators of problems related to effectiveness of the internal audit function, such as...</td>
</tr>
<tr>
<td>61</td>
<td>As paragraph 62 describes what the supervisor should consider and what the insurer should demonstrate, it is not really describing what would be exceptional circumstances, so suggest deleting “as described below”. Plus, as the text of the two paragraphs logically flow together, there is not a need to direct the reader.</td>
</tr>
<tr>
<td>62</td>
<td>Typo: ...assessing whether combination of the internal audit function with second line of defence control function...</td>
</tr>
<tr>
<td>67</td>
<td>Suggest revising the start of the paragraph to better reflect that the bullets are examples and not the only methods: Supervisors that use the work of the internal audit function use a variety of the following methods to assess the effectiveness of the internal audit function overall and specifically its ability to provide appropriate assurance on the work performed by other control functions, such as:</td>
</tr>
<tr>
<td>68</td>
<td>Typo: A decision about combining control functions... If the last sentence is illustrating proportionality, should it read: whereas in the case of smaller and less complex insurers, it may be appropriate for more than one function to be carried out by a single person or organisational unit.</td>
</tr>
<tr>
<td>78</td>
<td>Last bullet, it seems this is referring to things the insurer would put in place, not the supervisor. If so, using “regulations” may not be the correct wording, but rather something like “policies and processes”.</td>
</tr>
<tr>
<td>82</td>
<td>Second bullet, the rest of the paper does not refer to prudential and conduct supervision, plus some supervisors supervise both. This seems more of an offhand comment and could be deleted: The assessment of the effectiveness of the outsourced control functions, which is one of the main challenges for both prudential and conduct of business supervisors; and Third bullet, suggest clarifying whether this is intended to mean outsourced to third parties in other jurisdictions or outsourced to another legal entity within a group in another jurisdiction. Or both?</td>
</tr>
<tr>
<td>86</td>
<td>Typo: Supervisors address these challenges in various ways, including by</td>
</tr>
<tr>
<td>88</td>
<td>Suggest revising the last sentence to better reflect that the bullets are examples and not the only ways: Group-wide supervisors may address these challenges in the following ways various ways, including by:</td>
</tr>
<tr>
<td>89</td>
<td>Typo: ...or the insurance legal entity’s level control functions...</td>
</tr>
<tr>
<td>91</td>
<td>Suggest revising the last sentence to better reflect that the bullets are examples and not the only ways: These challenges can be addressed in the following ways various ways, including by:</td>
</tr>
<tr>
<td>93</td>
<td>Suggest revising the start of the paragraph to better reflect that the bullets are examples and not the only actions: Supervisors may take the following various actions to address challenges created by outsourcing of control functions within the group, such as: The first bullet is a bit confusing; suggest considering more straightforward wording. Third bullet, suggest “a combination” rather than “accumulation”.</td>
</tr>
<tr>
<td></td>
<td>Fourth bullet, it is not clear which Key Person and which legal entity “this” is referring to; suggest clarifying. Fifth bullet, for clarification: In case of outsourcing of a group-wide control function to an insurance legal entity, assess whether the team assigned to the within that insurance legal entity is performing adequately the coordination tasks belonging to a that group-wide control function;</td>
</tr>
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Draft: 4/1/21

International Insurance Relations (G) Committee
Virtual Meeting
February 3, 2021

The International Insurance Relations (G) Committee met Feb. 3, 2021. The following Committee members participated: Gary D. Anderson, Chair (MA); Bruce R. Ramge, Vice Chair (NE); Evan G. Daniels (AZ); Andrew N. Mais (CT); Karima M. Woods (DC); David Altmair (FL); Doug Ommen (IA); James J. Donelon (LA); Kathleen A. Birrane (MD); Anita G. Fox (MI); Chlora Lindley-Myers (MO); Marlene Caride (NJ); Jessica K. Altman (PA); and Raymond G. Farmer (SC).

1. Discussed NAIC Comments on the IAIS Draft Application Paper on Resolution Powers and Planning and Consultation on the Development of Liquidity Metrics

Commissioner Anderson explained that the International Association of Insurance Supervisors’ (IAIS’) draft Application Paper on Resolution Powers and Planning aims to provide guidance on supervisory practices related to resolution, which the IAIS defines as “actions taken by a resolution authority towards an insurer that is no longer viable, or is likely to be no longer viable, and has no reasonable prospect of returning to viability.”

Ryan Workman (NAIC) provided a detailed overview of the NAIC’s comments on the draft application paper, which were mostly editorial or for clarification.

Commissioner Anderson explained that the consultation on the development of liquidity measures is part of the IAIS’ development of its broader holistic framework for systemic risk that will serve as a tool for assessing insurers’ liquidity exposures and will help the IAIS to identify trends in insurers and the insurance-sector.

Mr. Workman provided a detailed overview of the NAIC’s responses on the consultation questions, including changes that were made in light of input received from interested parties in advance of the meeting (Attachment Two-A).

Director Daniels questioned whether the NAIC response to the first consultation question was meant to be read as the NAIC seeing the several metrics being developed as duplicative or complementary and suggested that clarification could be helpful.

Ralph Blanchard (Travelers) provided an overview of Travelers’ comments on the consultation, as well as on the draft NAIC responses, which highlighted flaws in some of the assumptions and approaches being used in Phase 1 of the liquidity metrics development process, including those that do not adequately reflect non-life insurance business. He suggested the need to address certain areas now instead of holding off until the Phase 2 consultation.

Director Ramge asked how the liquidity metrics being developed took into account different accounting treatments.

David Leifer (American Council of Life Insurers—ACLI) noted that the ACLI will be submitting its own comments, recommending that the IAIS needs to do more analysis on the differences of policy behavior, specifically in life annuities. He noted that the ACLI’s comments largely aligned with the NAIC’s comments.

Commissioner Anderson thanked Committee members and interested parties for their comments and asked Tim Nauheimer (NAIC) to respond to the points and questions raised. Mr. Nauheimer said that the NAIC response to the first consultation question was intended to convey that several metrics could provide different ways to achieve a similar outcome, not that they were duplicative, in part because the NAIC is supportive of the cash-flow approach being developed in Phase 2. He stated the points raised by Travelers were helpful as the IAIS liquidity metrics work progresses and encouraged Travelers to submit its own consultation responses. However, he noted the challenge of creating one ratio for both life and non-life insurers that would accurately be indicative of liquidity risk. Mr. Nauheimer acknowledged the concern that life insurance policies and annuities should be treated differently and would take it up as work continues within the IAIS. He also commented that different account treatments should not affect the liquidity metrics.

Commissioner Anderson suggested clarifying the NAIC’s response to the first question, to which Mr. Workman suggested revising the response to: “Yes, we agree with the IAIS phased approach to develop liquidity metrics for monitoring as different metrics may achieve the same goal and be comparable.”
Commissioner Caride made a motion, seconded by Director Ramge, to submit the NAIC’s comments as drafted on the Application Paper on Resolution Powers and Planning and to submit the NAIC’s responses, including the revisions proposed during the meeting, on the liquidity metrics consultation (Attachment Two-B). The motion passed unanimously.

Mr. Workman noted the IAIS had released another public consultation on its draft Application Paper on the Supervision of Control Functions, with comments due March 26. He noted that the internal review process is underway and that a Committee meeting will be scheduled accordingly prior to the submission date to review and approve the submission of any NAIC comments.

Having no further business, the International Insurance Relations (G) Committee adjourned.
# IAIS Draft Application Paper on Resolution Powers and Planning – NAIC Approved Comments

<table>
<thead>
<tr>
<th>Section/Paragraph</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>16 (editorial)</td>
<td>Such a situation generally occurs when a troubled insurer that is no longer viable, or is likely to be no longer viable, and has no reasonable prospect of returning to viability in its current form.</td>
</tr>
<tr>
<td>20 (editorial)</td>
<td>This however does not mean that policyholders will be fully protected under all circumstances and does not exclude the possibility that losses could be absorbed by policyholders, to the extent they are not covered by PPSs or other mechanisms.</td>
</tr>
<tr>
<td>22 (editorial)</td>
<td>Finally, resolution should seek to minimise any reliance on public funding.</td>
</tr>
<tr>
<td>27</td>
<td>Box 1, first sub-bullet, there should be a semi-colon rather than a period at the end of the bulleted text, for consistency.</td>
</tr>
<tr>
<td>32</td>
<td>Table 3 – some of the bullets are not capitalized, they should be capitalized for consistency.</td>
</tr>
<tr>
<td>32 (editorial)</td>
<td>While some resolution powers could be allocated to more than one group, this grouping is purely aimed at facilitating the reading by avoiding repetition in describing the powers and their benefits and uses.</td>
</tr>
<tr>
<td>66 (editorial)</td>
<td>The resolution authority may want to consider whether policyholder premiums should be adjusted post-write-down to reflect the write-down of their liabilities. The resolution authority should consider both protected and unprotected policyholders in line with the levels of protection provided to policyholders in their jurisdiction by the PPS, if applicable.</td>
</tr>
<tr>
<td>86</td>
<td>The second bullet states: “The existence of a PPS may affect timing of liquidation” The paper should provide more explanation of how a PPS can affect the timing of liquidation.</td>
</tr>
<tr>
<td>100</td>
<td>Suggest the procedures for effectuating the NCWOL principle include the potential impact of a PPS.</td>
</tr>
<tr>
<td>103</td>
<td>Second sentence, change “staggered” to “proportional” for alignment with section heading.</td>
</tr>
<tr>
<td>108</td>
<td>First bullet in second set of bullets – recommend this be written in US dollars for consistency with other IAIS documents.</td>
</tr>
<tr>
<td>111</td>
<td>Add a semi-colon after the last bullet in the first set of bullets for consistency.</td>
</tr>
<tr>
<td>114 (editorial)</td>
<td>An analysis of the impact of the failure of the insurance group on other parts of the financial system, or on the real economy, including the identification of any financial and economic functions that need to be continued to achieve the resolution objectives;</td>
</tr>
<tr>
<td>115</td>
<td>Include the following edits to improve clarity and grammatical flow: “In such cases, the group-wide supervisor and/or resolution authority should provide oversight, review and non-objection or approval of the resolution plan, including a The process that should require correction of any deficiencies.”</td>
</tr>
<tr>
<td>139</td>
<td>Include the following edits to improve clarity and grammatical flow: “In such cases, the group-wide supervisor and/or resolution authority should provide oversight, review and non-objection or approval of the resolution plan, including a The process that should require correction of any deficiencies.”</td>
</tr>
</tbody>
</table>
The Annex contains examples of legislation in four jurisdictions. It would be helpful to provide a more in-depth discussion of these laws, and how they function.

### IAIS Development of Liquidity Metrics: Phase 1 – Exposure Approach – *NAIC Approved Comments*

<table>
<thead>
<tr>
<th>Question / Response</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you agree with the IAIS’ plan for the development of liquidity metrics for monitoring? If not, please explain what changes you recommend and why.</td>
<td>Yes, we agree with the IAIS phased approach to develop liquidity metrics for monitoring as different metrics may achieve the same goal and be comparable.</td>
</tr>
<tr>
<td>2. Should the IAIS consider any other approaches or alternatives when developing liquidity metrics? If so, please explain.</td>
<td>No. We are happy to see the plan includes development of a company projection approach in Phase 2.</td>
</tr>
<tr>
<td>3. Should the IAIS develop additional liquidity metrics that examine other time horizons? If so, how should these metrics differ from the proposed metric?</td>
<td>Phase 2 should consider other time horizons as well as asset maturity and trading volumes over a period more consistent with the chosen time horizon.</td>
</tr>
<tr>
<td>4. Do you agree with the exclusion of separate accounts from the ILR? If not, how should separate accounts be incorporated?</td>
<td>Yes. However, we agree further metrics should be considered in the future. For certain products, the IAIS should review any potential residual risk in the general account.</td>
</tr>
<tr>
<td>5. Do you agree with the proposed factors for liquidity sources? If not, please explain.</td>
<td>No, we feel the asset factors are too low. We suggest they be based on empirical evidence such as market size, daily average trading volumes, and price volatility to determine appropriate factors, especially as the asset categories relate to each other. Absent empirical evidence, we are hesitant to recommend a percentage, but look to the factors used by S&amp;P as a logical starting point. In addition, the IAIS should take into account if the insurer has a diversified asset portfolio across business sectors. If an insurer’s investments have been concentrated on certain business sectors such as energy or financial services and not well diversified, then an overall haircut adjustment may be warranted.</td>
</tr>
<tr>
<td>6. Do you agree with the treatment of investment funds? If not, please explain and suggest an alternative treatment.</td>
<td>Yes, we agree to exclude them, but should review periodically if that is appropriate based on market conditions.</td>
</tr>
<tr>
<td></td>
<td>Question</td>
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</tr>
<tr>
<td>7</td>
<td>Do you agree with the treatment of premiums? If not, please explain how premiums and excluded expenses should be treated in the ILR.</td>
</tr>
<tr>
<td>8</td>
<td>How should instruments issued by financial institutions be treated within the ILR?</td>
</tr>
<tr>
<td>9</td>
<td>Do you agree with the inclusion of certain encumbered assets as liquidity sources within the ILR or should the IAIS alternatively exclude these encumbered assets and measure certain the related liquidity needs on a net basis? Should any additional liquidity needs be included in the calculation because encumbered assets are included as a liquidity source?</td>
</tr>
<tr>
<td>10</td>
<td>Do you agree with the treatment of liquidity risk from surrenders and withdrawals from insurance products in the ILR? If not, please explain how this could be improved.</td>
</tr>
<tr>
<td>11</td>
<td>How should the IAIS capture liquidity needs from policy loans? Should these be incorporated into the ILR or be an alternative metric?</td>
</tr>
<tr>
<td>12</td>
<td>Do you agree with the factors applied to retail insurance products being half of the factors applied to institutional products? How should the factors applied to retail and institutional policies differ?</td>
</tr>
<tr>
<td>13</td>
<td>Do you agree with the treatment of unearned premiums in the ILR? If not, how can it be improved?</td>
</tr>
<tr>
<td>Question</td>
<td>Response</td>
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<tr>
<td>Should the IAIS apply standardised factors to insurers projected ultimate catastrophe losses or rely on company projections for the speed of catastrophe payments and reinsurance recoveries?</td>
<td>Yes, but suggest conducting sensitivity analysis could be helpful.</td>
</tr>
<tr>
<td>We recommend using the companies 1/250 PML or 1/100 PML as an alternative for Phase 1 due to the ease of uniform data collection. Phase 2 should consider company projections.</td>
<td></td>
</tr>
<tr>
<td>Do you agree with the proposed treatment of catastrophe insurance claims? If not, how can it be improved?</td>
<td>Yes, but suggest conducting further analysis could be helpful; for example, an analysis of payouts within a year of a cat event may help improve requested data, especially for Phase 2.</td>
</tr>
<tr>
<td>Should the proposed treatment of deposit liabilities include more or less granularity? If so, what additional dimensions (eg the presence of an effective deposit insurance scheme) should be captured or left out?</td>
<td>We agree with the proposed treatment, with a less granular approach preferred.</td>
</tr>
<tr>
<td>Should the proposed factors be modified? If so, please explain how and why.</td>
<td>No, they look appropriate</td>
</tr>
<tr>
<td>Should insurance contracts without significant exposure to insurance events be captured by these factors, or included with other policyholder liabilities?</td>
<td>Yes, we believe such contracts warrant being captured by these factors and not just captured by other policyholder liabilities as the purpose is to capture the entire liquidity risk to insurer. For example, the exposure of the insurer to guaranteed investment contracts with no insurance riders attached to the contract should be captured.</td>
</tr>
<tr>
<td>Do you agree with the treatment of derivatives? If not, please explain and suggest an alternative treatment.</td>
<td>Yes, but suggest further historical analysis could be helpful.</td>
</tr>
<tr>
<td>How should the ILR treat debt with financial covenants that may be triggered under stress?</td>
<td>We believe that treating all (100%) of the category as being called, not rolled or not available under stress is too conservative. All debt that is short-term (i.e. commercial paper or long-term debt with maturity of less than a year) should be included. The stress event should be clearly defined. Any debt with covenants or collateral calls that are triggered by that specific stress event should only be included if there are provisions in the financial contracts that exclude them from the jurisdiction's bankruptcy code. The 100% factor on LT Debt appears too high as it is highly unlikely all the debt would be accelerated at once.</td>
</tr>
<tr>
<td>How should the ILR assess potential liquidity needs from a downgrade?</td>
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<td>February 2, 2021</td>
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We agree with 100% of the category affected by the downgrade, but “downgrade” needs to be clearly defined. We believe that a credit rating downgrade of the holding company of significant magnitude that triggers debt covenants and posting of higher collateral requirements for derivatives, securities lending, and repurchase agreements would be appropriate as a definition. In contrast, an insurers’ underlying debt or subsidiaries as well as investments are subject to frequent up and downgrades and thus should be excluded.

<table>
<thead>
<tr>
<th>22</th>
<th>Do you agree with the discussed limitations and mitigations of the ILR? What other limitations should the IAIS consider and how can these be mitigated when the IAIS monitors liquidity risk?</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Yes. The paper describes only one approximate measure of liquidity risk and such risk may be measured better with a cash flow approach, to be developed in Phase 2. Currently, renewal premiums, future claims from in force business and new business are not included. As these factors may affect the insurer’s liquidity position, one caveat of the current metric is that it will require more analysis of the insurer, on an ongoing basis, by the IAIS and the supervisor. Another issue the IAIS should consider is how to differentiate between a resolution with an orderly run-off, which will typically result in all claims being paid, and a liquidation due to a lack of liquidity.</td>
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<tr>
<th>23</th>
<th>General comments on the Public Consultation Document on the Development of Liquidity Metrics: Phase 1 – Exposure Approach</th>
</tr>
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<td></td>
<td>None.</td>
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We’d like to offer the following comments:

The proposed Insurance Liquidity Ratio (ILR) for Phase I has serious flaws and the NAIC should point these out in its response. The flaws are:

- **The use of only balance sheet values when looking at “Liquidity Sources” and “Liquidity Needs” over a one-year time horizon.** Liquidity sources over a one-year time horizon include premiums, investment income and investment maturities, even before consideration of asset sales. By focusing solely on the balance sheet the IAIS proposal is looking only at asset sales. Liquidity needs (claim liability runoff, new claims, expenses) offset some of those sources, but the degree to which that happens varies materially by company. Those that are in runoff or partial runoff (such as via exit of a long-tail line) might expect needs to consume most of the sources. Those that are going concerns or start-ups would expect sources to be greater (possible much greater) than needs, generating high levels of positive operating cash flows. In short, the use of only an exposure-based approach is materially inconsistent with a one-year time horizon.
  - We note that the Q22 response partially reflects this issue, but from a life insurance perspective as it makes no mention of the payout in the next 12 months of current claim liabilities, and focuses on “in force” business. We believe that response is insufficient as a result.

- **The use of only enterprise-wide calculations.** The use of only enterprise-wide calculations ignores the location of the liquidity sources vs. the needs. The paper points out on page 24 that the location of the funds matters, yet this is ignored in the design of the ratio. As a result, the proposed ILR is likely to propose false negatives (i.e., indicate that no liquidity concerns exist) in situations where liquidity concerns do exist.

- **Ignoring asset duration in its evaluation of liquidity sources.** In evaluating the degree to which asset values are available as liquidity sources, no reflection is made of the asset maturity. We believe that assets maturing in a shorter time frame would be more fully realizable in a crisis than those maturing in a longer timeframe.

- **Treatment of unearned premium as a liquidity need based partly on an archaic case study, and using an inadequately defined classification inconsistent with the available data.** The proposal would treat a certain portion of unearned premiums as a liquidity need, based partly on a 1933 case study for a surety insurer based in New York. A case study from 87 years ago is not relevant, given the changes in the environment (consumer, regulatory, financial, legal) since then. The proposed factors also vary for “retail” versus “institutional”. Such a classification is not sufficiently defined nor captured in the data for U.S. property/casualty insurers for it to be usable.

- **The catastrophe scenario is overly conservative with regard to the percent payout for an extreme event.** For property/casualty coverages affected by a catastrophe, the
larger the event the slower the payout. The 1-in-250 year scenario suggested would be larger than any recent event, and the largest recent events have payouts of over 12 months. Assuming that the event did not occur on January 1, the scenario suggested would have a payout of less than 12 months, making the suggested approach even more conservative. The result is an estimated liquidity need that is unrealistic. In addition, the longer the return period forecasted by catastrophe models, the more uncertain (if not speculative) the estimates become, making the quantification of this need unreliable.

Suggested edits to the NAIC response:

- Question 1 – Answer “No, as we believe that operating cashflow also needs to be considered, not just balance sheet values. In addition, we advise against enterprise-wide approaches that assume full fungibility of funds within a group.”
- Question 2 – Answer “Yes. We recommend recognizing operating cash flow consistent with the chosen time horizon, and investigating the use of entity-specific ratios rather than enterprise-wide ratios.”
- Question 3 – Modify the currently proposed answer to add consideration of asset maturity and trading volumes over a period more consistent with the chosen time horizon.
- Question 7 – Answer “No. We believe that recent historic operating cash flows should be reflected in the calculation. Such an approach is more consistent with the chosen time horizon, and reflects how many non-life insurers that do not have callable liabilities are currently managed.”
- Question 13 – Answer “We are not ready to agree or disagree until more information is collected with regard to recent situations. We do not believe the 1933 case study is sufficiently relevant to current times and, in addition, believe that the retail vs. institutional split proposed is not feasible or sufficiently defined for the U.S. property/casualty market.”
- Question 15 – Answer “No, as the percentage payout (i.e., 100%) is faster than that observed from the most extreme events in the relatively recent past. We also believe that catastrophe models are more reliable the shorter the return period, and conversely less reliable the longer the return period, such that estimates using a 1-in-250 year return period may not be sufficiently reliable. We recommend looking at percentage payouts within the year of occurrence from recent events, as well as investigating the reliability of catastrophe estimates for longer return periods. (The latter might be accomplished by comparison of various model estimates for various return periods.)”
- Question 19 – We believe that the proposed approach to derivatives is overly conservative, and recommend that the NAIC response reflect its experience with AIG’s derivatives during the 2008 financial crisis.
The International Insurance Relations (G) Committee met Jan. 6, 2021. The following Committee members participated: Gary D. Anderson, Chair (MA); Bruce R. Ramge, Vice Chair (NE); Andrew N. Mais (CT); Karima M. Woods (DC); David Altmaier (FL); Doug Ommen (IA); James J. Donelon (LA); Anita G. Fox (MI); Chlora Lindley-Myers (MO); Marlene Caride (NJ); Andrew R. Stolfi (OR); Jessica K. Altman (PA); and Carter Lawrence (TN).

1. Discussed NAIC Comments on the Joint SIF and IAIS Draft Application Paper on the Supervision of Climate-Related Risks in the Insurance Sector

Commissioner Anderson explained that the joint Sustainable Insurance Forum (SIF) and International Association of Insurance Supervisors (IAIS) application paper aims to provide background and guidance on how the IAIS supervisory material can be used to manage the challenges and opportunities arising from climate-related risks. Following an internal review, including by the Climate and Resiliency (EX) Task Force, draft NAIC comments were circulated on Dec. 15, 2020. He noted that no additional input from state insurance regulators or interested parties was received in advance of the conference call.

Ryan Workman (NAIC) provided a detailed overview of the NAIC’s comments on the draft application paper.

David F. Snyder (American Property Casualty Insurance Association—APCIA) thanked the NAIC for its continued efforts at the international level and engagement with interested parties. He provided an overview of the APCIA’s climate core principles, which guided its comments on the public consultation, highlighting core principles the APCIA would like the IAIS to focus on; and he relayed support for the NAIC’s comments as drafted.

Robert Neill (American Council of Life Insurers—ACLI) noted that the ACLI is working on its environmental, social and governance (ESG) principles, and he suggested that the IAIS work in this area should focus on how climate risks affect the IAIS’s core objectives related to insurance supervision, and broader policy decisions should be left to individual jurisdictions. He also stressed that IAIS guidance should remain flexible.

Commissioner Mais made a motion, seconded by Commissioner Caride, to approve the NAIC’s comments (Attachment Three-A). The motion passed unanimously.

Commissioner Anderson noted that the next calls of the Committee will be held on Jan. 21 and Feb. 3 to discuss additional IAIS public consultations.

Having no further business, the International Insurance Relations (G) Committee adjourned.

W:\National Meetings\2021\Spring\Cmte\G\Gmin_0106
## Joint SIF - IAIS Draft Application Paper on the Supervision of Climate-related Risks in the Insurance Sector – NAIC Approved Comments

<table>
<thead>
<tr>
<th>Section/Paragraph</th>
<th>Comment</th>
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<tbody>
<tr>
<td>3</td>
<td>Suggest taking the opportunity to elaborate here: Climate change presents not only risks but also opportunities for the insurance sector, such as being a driver for innovation.</td>
</tr>
<tr>
<td>11</td>
<td>Bottom of paragraph 11, suggest providing a footnote to A2ii and IDF work/initiatives in this area to provide additional reference and context for the reader.</td>
</tr>
<tr>
<td>Table 2</td>
<td>There is a missing period at the end of the table.</td>
</tr>
<tr>
<td>33</td>
<td>Last sentence; editorial, suggest: Also, the evolution of the non-financial performance of investee companies can be a relevant indicator for the variable remuneration.</td>
</tr>
<tr>
<td>77</td>
<td>Suggest avoiding paraphrasing of ICP 20 (this is the principle statement, not an objective) and for additional clarity: The objective of According to ICP 20 (Public Disclosure) is to the supervisor requires insurers to disclose relevant and comprehensive information on a timely basis in order to give policyholders and market participants a clear view of their business activities, risks, performance and financial position which enhances market discipline. Public disclosures on emerging(ed) risks, including climate change, are of primary relevance to this objective. In establishing disclosure requirements for climate risks, the supervisor should take into account existing relevant requirements as well as proprietary and confidential information that could negatively influence the competitive position of an insurer if made available to competitors.</td>
</tr>
<tr>
<td>88</td>
<td>Fourth sentence; editorial, suggest: They should also describe the actions taken as reaction in response to climate change risks.</td>
</tr>
<tr>
<td>After page 90 in Box 5 Examples of supervisory practice on disclosure requirements - United States</td>
<td>Insurers were encouraged to incorporate FSB TCFD guidelines when answering the survey in the Reporting Year 2018 NAIC Climate Risk Disclosure Survey 2019 which could effectively align the survey with the TCFD guidelines. For the Reporting Year 2019 NAIC Climate Risk Disclosure Survey, due from insurers in August 2020, participating insurers were allowed to submit a TCFD report. Eight groups and eight individual insurers submitted a TCFD report in the Reporting Year 2019 NAIC Climate Risk Disclosure Survey.</td>
</tr>
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</table>
AGGREGATING REGULATORY CAPITAL REQUIREMENTS ACROSS JURISDICTIONS:
THEORETICAL AND PRACTICAL CONSIDERATIONS

American Academy of Actuaries
Research Paper 2021, No. 1
This research paper was written primarily by Steve Jackson, Ph.D., assistant director for research (public policy), American Academy of Actuaries ("Academy"). The paper was sponsored by Tom Wildsmith, Academy international secretary with advice and guidance from Academy members Elizabeth Brill, Maryellen Coggins, and William Hines. The paper also benefited from discussions with and helpful comments by Carmen Suro-Bredie, Qamar Islam, Ned Tyrrell, Matt Walker, and members of the Academy’s Solvency Committee.

The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policy makers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
EXECUTIVE SUMMARY

Aggregating Regulatory Capital Requirements across Jurisdictions: Theoretical and Practical Considerations

Especially since the financial crisis of 2007–08, regulators in the U.S. and around the world have recognized that the solvency of insurance groups as well as that of their individual legal entities needs to be examined. Efforts toward global regulatory convergence were launched by the International Association of Insurance Supervisors (IAIS), initiated by the Financial Stability Board (FSB). These efforts include the negotiation of a group solvency capital standard for all Internationally Active Insurance Groups (IAIGs): Insurance Capital Standard 2.0 (ICS 2.0). The approach the IAIS has taken with the International Capital Standard has been largely resisted by regulatory and industry stakeholders in the United States (and some other countries) based on the nature of its current regulatory structures. The IAIS has agreed to consider an alternative approach based on comparability with ICS 2.0—referred to as the aggregation method (AM).

The AM was born of practical necessity. In the United States, the Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank) requires the Federal Reserve Board (FRB) to regulate holding companies, which include banks and insurance companies. In 2016, an FRB paper proposed a building block approach (BBA) to regulate the capital of these mixed entities. As banks and insurance companies do not “share any common capital assessment methodology,” the FRB proposed relying on the existing methodologies for each sector and to aggregate capital requirements across regulatory frameworks with the use of a “translating mechanism” called a “scalar.”

This paper is offered to help clarify the objectives, both conceptual and practical, of a scalar methodology. It assembles an inventory of possible methodologies. It derives a set of criteria for the evaluation of methodologies from existing discussions of possible methodologies and from standard statistical principles. It evaluates each of the methodologies according to the specified criteria.

Scalars are designed to allow regulators in a jurisdiction to have access to a metric of the capital adequacy of an insurance group—or more generally, of a financial services group—based on the capital adequacy metrics of its individual components, including those entities regulated in other jurisdictions. While scalars might be developed for all kinds of entities, the focus of this paper is on scalars for entities regulated by jurisdictions that specify a measure of capital adequacy based on the ratio of some measure of available capital to some measure of the risk inherent in their operations. This measure of inherent risk (which is also referred to as “required capital” in this paper) might vary: for insurance, it might express the capital required to account for asset, interest rate, underwriting and/or other risks; for banking, it might express a risk-weighted measure of assets.

The ideal form of scalars is one where an entity in one jurisdiction hypothetically calculates its available and required capital as if it operated in the originating jurisdiction while adjusting (or controlling for) other factors that might affect the safety of the group’s ongoing operations. Of course, this conceptual “ideal” may be impractical requiring, as it would, each entity with ownership in a different jurisdiction to maintain two sets of books: one with accounting principles and solvency measures calculated according to local requirements and a second one aligning with the principles and practices of the jurisdiction of its ownership. This ideal might also require adjusting for all other relevant factors, and doing so in a manner that recognizes the possibility that different accounting practices and/or different levels of safety inherent in calculations of required capital might already reflect awareness by jurisdictional regulators of some or all of these other factors.

As this analysis examines possible scalar methodologies, four independent general criteria for assessment are introduced: validity, reliability, ease of implementation, and stability of parameters. Translating these criteria to explicitly apply to scalars and elaborating on specific factors that might be assessed under each of these four general criteria make the report’s assessments more comparable and more useful.

Four families of methodology for estimating scalars are assessed: No Scalars, Capital Ratios, Equivalence of Two Points, and Probability of Negative Outcomes. One of these families—Equivalence of Two Points—turns out to be a generalization of two other families. Each of the three distinct families include multiple variants. Two variants from each of two families are specifically assessed and the variants of the third family are assessed as a group. The evaluation of these methodologies by the criteria just suggested presents issues to consider, sometimes applying to all branches of a family and sometime applying to one branch but not others.
The assessments presented here suggest not only that any scalar methodology will be imperfect; they also suggest that the extent to which the results produced will vary from the “ideal” is itself variable, depending on the circumstances (e.g., how much of a company’s business is accounted for by entities in other jurisdictions). As a result, a final determination on preferred scalar methodologies likely will vary due to circumstances.

To summarize roughly the assessments of the five methodologies which are assessed in detail, it is useful to conceptualize two dimensions based on our four criteria of assessment: 1) validity; and 2) simplicity. Validity includes both conceptual validity as discussed in the paper and the lack of validity that follows from a lack of reliability. Simplicity includes both conceptual simplicity (discussed as part of validity) as well as ease of implementation. The best scalar methods would be very simple and highly valid. Unfortunately, none of the methods assessed here fit that description. Indeed, there is an ordinally inverse relationship between validity and simplicity, as can be seen in Figure A.

**Figure A: Validity and Simplicity of Scalar Methodologies**

![Figure A: Validity and Simplicity of Scalar Methodologies](image)
Four issues arise to a greater or lesser extent for all of the methodologies assessed, and it seems prudent to highlight them before concluding. Those issues are:

1. **The application of these methodologies to entities in different industries:**
   Jurisdictions differ by geography and/or by industry. The regulatory regime in a given geographic unit defines a jurisdiction. Most of the comments in this paper apply to scalars for entities in different jurisdictions, whether the basis for the difference is geography, industry, or both. However, it is true for all methodologies (with the exception of one of the No Scalar methods) that when the entities are in different industries, a second scalar element is required.

2. **The dependence of the anchors for these methodologies on regulatory actions and company responses (the "problem of endogeneity"):**
   For all methods discussed in this paper (with the exception of one of the two No Scalar approaches), the anchors of these methods (e.g., the Capital Adequacy ratio, or the Probability of Default), are the result, in part, of companies acting under regulatory requirements. As illustrated in this paper, scalars may adjust for the differences in those requirements. However, anchors also reflect the actions of regulators within the various regulatory systems, and the responses of companies to those actions. The anchors then are products both of the different requirements (for which scalars aim to adjust) and the responses of regulators and companies to those anchors.

3. **The dependence of stability and validity of results on jurisdictional regime stability:**
   For all methods discussed here, and likely for any other methods that might be contemplated, the validity of the results, and their stability over time, depends on regime stability.

4. **The value of sensitivity testing in selecting a most desirable method:**
   In discussing the role of sensitivity testing throughout this paper, two different dimensions of sensitivity have been implied: 1) sensitivity of results to changes of parameters within a model; and 2) sensitivity of results to differences in methods of calculating scalars.

This paper provides a discussion of these issues in more detail as well as possible responses. As with scalars themselves, there are no perfect solutions.
While the Academy offers the considerations presented in this paper to be taken into account by regulators as they consider adoption of scalars as part of the group capital regulation process, the Academy does not make any specific recommendations in favor of or against any particular methodology. However, three conclusions do seem to follow from the analysis presented here:

1. Methodologies based on observable data are preferable to methodologies based on assumption, other things being equal. Only the approaches discussed under the Probability of Negative Outcomes are defined by reference to the analysis of observable data, and thus deserve heightened attention in any regulatory environment. However, as discussed, with the advantage of reliance on data come several challenges—many of them directly related to the reliance on available data. As such, regulators should consider whether adoption of this methodology, the Probability of Negative Outcomes, is advisable especially after careful consideration.

2. Almost all methodologies will be prone to increased imperfection if regulatory regimes change in a manner affecting capital adequacy standards after scalars have been estimated. While there might be attempts to develop methods by which to calculate adjustments to scalars based on the changes observed, the optimal way to adjust scalars for regime change and other changes in relevant conditions is to recalculate the scalars periodically. Hence, it may be advisable for a periodic recalculation to be made as an intrinsic element of any methodology adopted.

3. All of the methodologies discussed here are and will be imperfect. While factors that might be addressed to reduce some of those imperfections have been identified, it is impossible to find perfect solutions given the criteria of validity, reliability, ease of implementation, and stability of parameters and results. The question facing regulators then involves balancing degrees of validity (i.e., how imperfect the measures are, given what they would be if ideally conceptualized and measured) against degrees of reliability, ease, and stability. The only reliable way in which to regard those degrees, and to provide meaningful information with which to select a methodology based on some optimization of the criteria, is through the application of sensitivity testing as described. Hence, it may be advisable that the information required to examine the impact of each selected methodology under varying parameters, and to compare the impact of differing methodologies, be collected by regulators in order to allow them, at least initially, to rely on sensitivity testing to determine the best scalars in a particular jurisdiction.
The complete version of this research report will be released in the coming days; you will be able to access the report at actuary.org/.scalars.
NAIC/CONSUMER LIAISON COMMITTEE

NAIC/Consumer Liaison Committee April 8, 2021, Minutes ................................................................................................ 13-2
NAIC/American Indian and Alaska Native Liaison Committee March 16, 2021, Minutes (Attachment One) .................. 13-7
The NAIC/Consumer Liaison Committee met April 8, 2021. The following Liaison Committee members participated: Michael Conway, Chair, and Debra Judy (CO); Andrew R. Stolfi, Vice Chair, and Tricia Goldsmith (OR); Lori K. Wing-Heier and Sarah Bailey (AK); Jim L. Ridling, Jimmy Gunn and Dusty Smith (AL); Alan McClain and Crystal Phelps (AR); Peni Itula Sapini Teo represented by Elizabeth Perri (AS); Evan G. Daniels, Maria Ailor, Vanessa Darrah and Erin Klug (AZ); Ricardo Lara, Lucy Jabourian, Pam O’Connell and Camilo Pizarro (CA); Andrew N. Mais and Kurt Swan (CT); Karima M. Woods, Howard Liebers, Sharron Shipp and Cheryl Wade (DC); Trinidad Navarro and Christina Haas (DE); David Altmaier, Alexis Bakofsky, John Reilly and Chris Struk (FL); John F. King and Martin Sullivan (GA); Doug Ommen, Jared Kirby and Sonya Sellmeyer (IA); Dean L. Cameron, Kathy McGill, October Nickel and Randy Pipal (ID); Vicki Schmidt and LeAnn Crow (KS); Sharon P. Clark and Ron Kreiter (KY); Kathleen A. Birrane and Joy Hatchette (MD); Anita G. Fox and Renee Campbell (MI); Grace Arnold, Peter Brickwedde and T.J. Patton (MN); Chlora Lindley-Myers, Cynthia Amann and Carrie Couch (MO); Mike Chaney and Andy Case (MS); Mike Causey represented by Tracy Biehn and Kathy Shortt (NC); Jon Godfrey, John Arnold and Chris Aufenthie (ND); Bruce R. Ramge, Laura Arp, Martin Swanson and Reva Vandevoorde (NE); Barbara D. Richardson and David Cassetty (NV); Linda A. Lacewell, Mark McLeod and My Chi To (NY); Tynesia Dorsey and Jana Jarrett (OH); Glen Mulready (OK); Jessica K. Altman, Katie Dzurec, Sean McDaniel (VT); Scott A. White, Don Beatty, Kathy McGill, October Nickel and Randy Pipal (VT); Sean McDaniel (WV); and Donna Stewart (WY). Also participating were: Kathleen Nakasone (HI); Karl Knable (IN); Robert Wake (ME); Jeannie Keller (MT); Chris Nicolopoulos (NH); Russel Toal and Paige Duhamel (NM); Elizabeth Kelleher Dwyer and Matt Gendron (RI); Glynnda Daniels (SC); Jill Kruger (SD); Jennifer Ramcharan (TN); Jonathan Spencer (VT); Sean McDaniel (WV); and Donna Stewart (WY).

1. **Heard Opening Remarks**

Commissioner Conway said the Consumer Board of Trustees is composed of six state insurance regulator members and six funded consumer representative members. He said the Board meets in closed, confidential sessions because it administers the NAIC Consumer Participation Program, which may require discussions of a confidential nature concerning personal information. He said the full Board will meet to discuss possibly revising the Plan of Operation for the NAIC Consumer Participation Program and two Consumer Representative Requests for NAIC Action on April 9.

2. **Heard a Presentation on Federal Health Care Reform Developments and the Impact on States**

Katie Keith (Out2Enroll) said the American Rescue Plan Act of 2021 (ARPA) affects subsidies for marketplace shoppers and people who are uninsured in many ways. She said the number of people eligible for marketplace subsidies has increased from 18.1 million to 21.8 million people, with most of that attributable to eligibility being extended to those making 400% over the poverty level nationwide. She said the ARPA included an average savings of $70 per month for 9 million current marketplace enrollees. She said half of the uninsured population is now eligible for free or nearly free coverage through Medicaid or a $0 premium marketplace plan. She also said at least 5.2 million people qualify for the equivalent of platinum coverage, which is a $0 premium plan with cost-sharing reductions (CSRs) and an average deductible of $177. She said if all states expanded Medicaid, the federal government would contribute $16.4 billion in increased Federal Medical Assistance Percentages (FMAPs) for traditional Medicaid spending when states contribute $6.8 billion for Medicaid expansion. She said the FMAPs are the percentage rates used to determine the matching funds rate allocated annually to certain medical and social service programs, such as Medicaid, in the U.S. She also said Medicaid expansion is associated with decreases in individual market premiums. She said her recommendations for state insurance regulators are to: 1) increase their marketing, outreach and support by emphasizing the new financial help and coverage options available under the ARPA; encouraging insurers to help consumers understand their options; coordinating with other agencies, such as unemployment agencies; partnering with organizations that work with underserved communities, especially immigrants and their family members; and working to reach those enrolled in non-federal Affordable Care Act (ACA) plans who now qualify for financial help; 2) allow consumers to enroll or change plans under with employers and consider additional Special Enrollment Periods (SEPs) for job loss or based on income; and 3) expand state Medicaid programs.

Lucy Culp (Leukemia & Lymphoma Society—LLS) said 30 patient organizations, including the LLS, recently released a report entitled, “Under-Covered: How ‘Insurance-Like’ Products are Leaving Consumers Exposed.” She said this report illustrates...
the significant risk patients face when they enroll in subpar plans because it focused on eight types of non-ACA compliant coverage sold as providing minimum Essential Healthcare Benefits (EHBs), such as grandfathered plans, health care sharing ministries (HCSMs), Simplified Employee Health Care Plans, Multiple Employer Welfare Associations (MEWAs), self-insured plans, and shared Employee Retirement Income Security Act of 1974 (ERISA) plans. She said the report chronicles the stories of six patients who struggled with their health and finances after their plans refused to cover treatment or pay for it; i.e., “under-covered” consumers who needed health care. She said Megan Martinez, an insurance consumer in Texas faced with emergency surgery, got her surgery pre-approved by her HCSM, paid her $5,000 member fee, and received a hospital bill for $126,000, indicating that the company denied coverage because it was a pre-existing condition. Ms. Culp said the Texas Department of Insurance (DOI) found that the company was not licensed in Texas, so the DOI forced the company to pay the bills, as well as a hefty fine. She said federal policy recommendations point to federal rulemaking, such as the 2022 Payment Notice, the federal No Surprises Act (NSA), and additional pandemic guidance. In states, there is an impending decision for California v. Texas which poses an extreme risk for consumers and states if the ACA is not upheld. Ms. Culp said opportunities for states and NAIC advocacy include continuing the timely implementation of APRA changes; urging the U.S. Congress (Congress) to make these enhancements permanent; protecting patients from subpar plans; and urging Congress and the Biden Administration to fix the family glitch.

Commissioner Lara said the coverage gap needs to be closed in that the discrimination clause prevents immigrants from paying into the ACA so immigrants end up in the emergency room for treatment. He said there is no excuse for it, and Congress needs to allow immigrants to pay into the ACA because they are hard-working people who are able to pay and who want to pay their way into it. Ms. Keith said the ARPA does not allow this either, but she said that the current administration could allow it under the Deferred Action for Childhood Arrivals (DACA); or, she said states could use Section 1332 waivers to allow it. Commissioner Lara said California is going to use a Section 1332 waiver to do it. Commissioner Conway said Erin Miller (Colorado Children’s Campaign) would be speaking to this issue for Colorado during her presentation.

3. Heard a Presentation on the Enforcement Needed to Ensure Health Care Compliance with HIV Preventive Drug Requirements

Wayne Turner (National Health Law Program—NHeLP) said pre-exposure prophylaxis (PrEP) can help prevent future infection. He said it was approved by the National Health and Food Administration (FDA) in 2012 and recommended by the U.S. Centers for Disease Control and Prevention (CDC) in 2014 for HIV prevention. Rather than a cure, he said it is a once daily medication regimen with three drugs that are now approved (Truvada, Descovy and generic Truvada). He said PrEP requires office visits, HIV and Hepatitis B tests, as well as other periodic lab tests to monitor liver and kidney function. However, he said PrEP reduces the risk of contracting HIV by approximately 99%. He said black and Hispanic/Latina communities are disproportionately affected by HIV because those with the highest risk have the lowest access. He said only 18% of Americans who could benefit from PrEP are taking the medication. He also said the gaps in PrEP coverage are highest among gay and bisexual men of color and transgender women. He said the ACA requires non-grandfathered individual and small group plans to cover 10 EHBs, including preventive services with no cost sharing. He said in June 2019, the U.S. Preventive Services Task Force (USPSTF) issued an “A” rating for PrEP for certain at-risk populations, and in January 2021, all EHB plans must cover PrEP without cost sharing. He said PrEP medications are not yet included on the federal healthc are.gov list of preventive services, which is important because some plans still link to this list when determining coverage. He said the PrEP ancillary services, such as colonoscopies should be included without cost sharing, as reiterated by the Interim Final Rule (IFR) in December 2020. He also said the federal Frequently Asked Questions (FAQ) on PrEP is also still pending. He said state actions taken by California, Colorado and New York include regulations or guidance requiring coverage of PrEP, as well as various levels of coverage for ancillary services without cost sharing.

Carl Schmid (HIV+Hepatitis Policy Institute) said while spot checking of formularies during the Open Enrollment Period in November 2020, he found many plans in compliance by offering at least one PrEP medication without cost sharing, but several plans were not in compliance and had transparency issues. When he reid the spot checking in March 2021, he found greater compliance and some transparency improvements, but there were still some violations. He said one concern was a general lack of consistency and transparency in that PrEP was noted on formulary tier 4 on plans that listed other preventative medications on tiers 0 or 5. He said recommended next steps state insurance regulators should consider include reviewing plans to ensure that at least one PrEP medication with $0 cost sharing; ensuring for other plans, if medically necessary, coverage of ancillary services without cost sharing by issuing guidance or regulations; responding to and tracking beneficiary complaints; and preparing for new PrEP medications in the future, such as long-acting injectable, oral and implantable medications.

Commissioner Conway said Pfizer had indicated future research into a new PrEP medication pinging off its COVID-19 vaccine.
4. **Heard a Presentation on How Commissioners Can Help Improve Maternal Health Outcomes**

Dorianne Mason (National Women’s Law Center—NWLC) said the disparities in black, indigenous and Latina maternity issues of coverage, care and community need to include contiguous coverage. She said in 2017, 22% of black and 29% of indigenous patient complaints were being ignored. She said an increase in access by policy will increase care by way of the federal black maternal health policy called Momnibus, which includes a 12-month postpartum Medicaid extension.

Jamille Fields Allsbrook (Center for American Progress) said recommendations for improvements in maternal health outcomes include network adequacy standards being expanded to ensure access to quality providers; coverage for midwives and doulas, as well as Certified Professional Midwives (CPMs) and Certified Midwives (CMs); and culturally competent care provided by encouraging training on implicit bias and anti-racism. She said the ignorance and lack of special cultural needs can be life threatening, as many black and indigenous women will not participate when faced with care standards that are outside of their traditions. However, she said better health for the mother and the baby are the result of insurers providing this type of out-of-the-norm care like flexible hours for people who are employed in jobs during off hours making it hard for them to get off work during the day for appointments, saving up to $1 billion or $884 per pregnancy in one year. She said EHB benchmark selection should include robust pre-natal and post-natal services; coverage for birth centers and home births (those outside of facilities, which are currently excluded from many plans); and ensuring that the following ACA requirements are met with no cost sharing: maternity coverage for dependent enrollees, women’s preventive services, no arbitrary limits on services, coverage of breastfeeding education and breast pumps. She said states; efforts to improve coverage could include SEPs for pregnancy, innovative care models, quality measures, Medicaid postpartum coverage extension, and data collection.

Commissioner Conway said he understands that the presentation just scratched the surface of coverage disparities in just one type of health care, but he is thankful to get the conversation started and he applauds their efforts. Commissioner Altman said as chair of one of the workstreams under the Special (EX) Committee on Race and Insurance, she is interested in whether the presenters found any examples of states who did well in this area. Ms. Allsbrook said there were lots of good actions and pieces, but no good model in all areas. She said Vermont includes maternity care in its EHB benchmark; Washington has no limit on a mother’s inpatient care; and Massachusetts has a task force working on network adequacy. Commissioner Lara said more time is needed to discuss important issues like this, and he suggested that this meeting be split into two sessions. He suggested that a list of model laws applicable to the topic be included and that the System for Electronic Rate and Form Filing (SERFF) public-facing Application Programming Interface (API) be looked at regarding language barriers and missing groups.

5. **Heard a Presentation on Addressing Coverage Losses Among Kids**

Steven Lopez (UnidosUS, formerly the National Council of La Raza) said the benefits of health coverage for children are that insured children are less likely to postpone care, resulting in fewer preventable hospitalizations and missed diagnoses; coverage increases the likelihood of high school and college completion because children do better in school and have better financial futures; and uninsured women are more likely to have adverse maternal outcomes and complications. He said since 2017, the Latino child uninsured rate has risen from a low of 7.7% to 9.2% in 2019. In 2018, he said the gap between health coverage rates for Latino children and all children widened for the first time in a decade, and the national child uninsured rate rose to 5.7% in 2019, amounting to 4.4 million children nationwide. He said millions of children were dropped off coverage that they desperately need. He also said coverage needs to be returned, expanded, and continued.

Courtney Bullard (Utah Health Policy Project—UHPP) said Utah has seen a steady uptick of uninsured children. She said Utah has one of the highest rates of uninsured children in the nation, 82,000 children (8%); the highest rate of uninsured Hispanic, Latinx and immigrant children in the nation (19%); and the highest rate of children currently eligible for health insurance, but not enrolled. She said Utah Medicaid Expansion passed via ballot initiative in 2018, and Medicaid enrollment has increased by 33.3% in Utah since March 2020, which is the second highest increase in the nation. She also said enrollment in the Children’s Health Insurance Program (CHIP) began to increase for the first time in several years. She said policy steps to covering more kids were that the Kids Coverage Amendments passed 2021 legislative session and community collaboration and buy-in were obtained on outreach and enrollment. However, expanding pregnancy Medicaid failed during the 2021 session, and fixing the family glitch was removed from the ARP.

Ms. Miller said in Colorado, policymaking to provide coverage for uninsured children (in 2019, numbering enough to fill nearly every seat in the Broncos’ Stadium) began with legislative partners and Senate Bill 20-215. She said the Colorado Children’s Campaign funded the state reinsurance program; funded cost sharing; expanded coverage for those left out due to the employer family glitch, etc.; and provided coverage for undocumented Colorado taxpayers who previously had no access. She said state insurance regulators can improve policy through Medicaid, CHIP, and private coverage and improve outreach through government officials, community-based groups, and welcoming rhetoric.
Commissioner Lara said he grew up without health care, but eventually he was able to get it through Mexico.

6. **Heard a Presentation on a Comprehensive Approach to Addressing Systemic Racism in Insurance**

Birny Birnbaum (Center for Economic Justice—CEJ) said according to a recent University of Georgia report on “Racism and the Contamination of Black Lives” published in the *Journal of African American Studies*, structural racism is the policies and practices that normalize and legalize racism in a way that creates differential access to goods, services and opportunities based on race. Environmental racism refers to policies, practices or directives that result in advantages or disadvantages to individuals or communities based on race. Mr. Birnbaum said systemic racism can manifest itself in insurance marketing, pricing and claims settlement by the intentional use of race called disparate intent; by disproportionate outcomes tied to historic discrimination and embedded in insurance outcomes called disparate impact; and by disproportionate outcomes tied to the use of proxies for race, not to outcomes called proxy discrimination. He said disparate impact and proxy discrimination are unnecessary to insurance, as they only predict race; they do not predict risk. Therefore, state insurance regulators should put a stop to these practices. He said the basic formula that is currently an insurance company standard uses race in the analysis, but it does not use race in the outcome. He said it is not reasonable or necessary to recognize disparate impact as unfair discrimination in insurance because it makes no sense to permit insurers to do indirectly what they are prohibited from doing directly. He said if the goal is to prevent racial discrimination in insurance, practices that have the same effect should not be banned, even if such practices reduce risk and costs, because systemic racism in an era of big data means that there are no facially neutral factors.

Mr. Birnbaum said the “Coded Bias” movie showed advocates of algorithmic techniques, arguing that data mining eliminates human biases from the decision-making process, but an algorithm is only as good as the data it works with. He said it is possible for data mining to inherit the prejudices of prior decision makers or reflect the widespread biases that persist in society at large. He said the patterns that data mining discovers are often simply preexisting societal patterns of inequality and exclusion. He said unthinking reliance on data mining can deny vulnerable groups full participation in society. He said the fact that an insurer does not use race in an algorithm does not logically or factually result in no racial discrimination. In fact, he said the only way to identify and eliminate the impacts of structural racism in insurance is to measure that impact by explicit consideration of race and other protected class factors.

Mr. Birnbaum said disparate impact is the use of a non-prohibited factor that causes disproportionate outcomes based on prohibited class membership in such a way that disproportionate outcomes cannot be eliminated or reduced without compromising the risk-based framework of insurance. He said proxy discrimination is the use of a non-prohibited factor that, due in whole or in part to a significant correlation with a prohibited class characteristic, causes unnecessary, disproportionate outcomes based on prohibited class membership. He said these definitions should be implemented by: 1) requiring insurers to test for disparate impact and proxy discrimination; 2) eliminating proxy discrimination; 3) minimizing disparate impact; 4) reporting test results to state insurance regulators and the public; 5) creating a safe harbor for insurers who do this using methods accepted by state insurance regulators; 5) establishing equity standards for minimizing disparate impact by seeking approaches that reduce disparate impact without compromising efficiency of the algorithm; and 6) establishing an equity/efficiency trade off of 20-to-1; i.e., reduce algorithmic efficiency by 2% if disparate impact can be reduced by 40% or more.

Mr. Birnbaum said some insurer executive officers have spoken out against racism in insurance, and some insurance trade associations have opposed state and federal proposed changes to end disparate impact and proxy discrimination, including the Casualty Actuarial and Statistical (C) Task Force white paper because it suggested that insurers be asked to show a rational relationship between new data sources and insurance outcomes. He urged state insurance regulators to reject the definition of proxy discrimination that the National Council of Insurance Legislators (NCOIL) adopted because it would block any efforts to identify or address disparate impact and proxy discrimination, as well as shield insurers from any accountability for such practices. He applauded the efforts of the NAIC, individual states, individual insurance trades, and individual insurers to examine, measure and improve racial diversity in leadership and throughout their organizations. However, he said the following concrete steps within a comprehensive framework are still needed: 1) recognize disparate impact and proxy discrimination against protected classes as unfair discrimination; 2) require insurers to test for and minimize disparate impact in all consumer-facing operations; 3) develop acceptable methods of testing and reporting results for disparate impact to the public; 4) develop a data reporting framework for the analysis of insurance availability and affordability of insurance in communities of color; 5) charge NAIC committees, task forces and working groups to identify practices that may perpetuate racial discrimination; 6) charge NAIC committees with identifying policies that unfairly discriminate on the basis of race, including low-value products targeted at communities of color; 7) commit to more consumer participation from communities of color in NAIC events so consumer stakeholder participation equals that of industry stakeholders; 8) direct committees, task forces and working groups to implement the NAIC’s Principles on Artificial Intelligence (AI) because insurers’ use of big data and AI has increased the potential for proxy discrimination and disparate impact; and 9) update advisory organization models, as efforts to implement
the NAIC’s AI principles and address systemic racism in insurance must modernize and expand the reach of state advisory organization laws.

Commissioner Stolfi said Oregon agrees that the definition proposed by NCOIL is incorrect, and he hopes NCOIL will reconsider it. Commissioner Conway said more time will be allotted in the future to discuss it.

7. Heard a Presentation on the Short-Term and Long-Term Recovery of Texas in the Aftermath of Catastrophic Disaster

Amy Bach (United Policyholders—UP) said collaboration opportunities for optimizing disaster recovery assistance, like facilitating the flow of accurate information and insurance dollars to overwhelmed, traumatized people, need to be taken. She said insurance and banking regulatory agencies issue notices and bulletins; extend deadlines and negotiate claim handling reforms with industry; arrange town halls, recovery events, and consumer assistance hotlines; facilitate lender releases on insurance checks; alert consumers to fraud scams and provide consumer education on prevention; and oversee contractor licensing. She said the UP Roadmap to Recovery™ program provides trained volunteers with personal experience from previous disasters using its 30 years of experience in providing empathy, technical information, and guidance on insurance and financial decision-making. She said collaboration is also essential with long-term recovery groups, National Voluntary Organizations Active in Disaster (VOADs), and disaster case managers.

Ms. Bach said UP worked closely with California, Colorado and Oregon following wildfires in their states on providing consumers with insurance and recovery help. She said this led in part to Oregon’s Wildfire Rebuild Agreement and voluntary claim handling reform in California. She said the Oregon Division reached an agreement with several insurance companies to provide at least two years from the date of loss for people to rebuild their homes and provide the ability for people to rebuild at a different location should they so choose. She said Tony Cignarale, California’s Deputy Commissioner, oversees disaster response, the consumer hotline, requests for assistance, and market conduct examinations. She said Mr. Cignarale also helped enact many of the laws in place that help disaster survivors collect insurance benefits in a timely manner. She announced upcoming town hall meetings and tele-town hall meetings in all three states.

Having no further business, the NAIC/Consumer Liaison Committee adjourned.
The NAIC/American Indian and Alaska Native Liaison Committee met March 16, 2021. The following Liaison Committee members participated: Lori K. Wing-Heier, Chair (AK); Jeff Rude, Vice Chair (WY); Michael Conway (CO); Trinidad Navarro (DE); Dean L. Cameron represented by Randy Pipal and Kathy McGill (ID); Grace Arnold (MN); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Tracy Biehn and Kathy Shortt (NC); Jon Godfread represented by John Arnold (ND); Glen Mulready (OK); Andrew R. Stolfi (OR); Larry D. Deiter (SD); and Mike Kreidler (WA). Also participating were: Russel Toal and Paige Duhamel (NM).

1. **Adopted its 2020 Fall National Meeting Minutes.**

Director Wing-Heier congratulated Commissioner Mulready on Oklahoma working successfully with its tribal partners to provide COVID-19 vaccine to all ages.

Commissioner Kreidler made a motion, seconded by Ms. Shortt, to adopt the Committee’s Nov. 16, 2020, minutes (see NAIC Proceedings – Fall 2020, NAIC/Consumer Liaison Committee, Attachment One). The motion passed unanimously.

2. **Heard a Presentation on COVID-19 Vaccine Distribution and Usage in Washington.**

Lou Schmitz (American Indian Health Commission for the state of Washington—AIHC) said the AIHC was created in 1994 by Washington’s federally recognized tribes and urban Indian health programs (UIHPs) to address tribal–state health issues. She said AIHC’s mission is to improve the health of American Indian and Alaska Native (AI/AN) people through tribal-state collaboration on health policies and programs. Ms. Schmitz said the AIHC’s work is directed by the 29 federally recognized tribes and two urban Indian health programs in the state. She said delegates are officially appointed by Tribal Councils and urban Indian health organization boards to represent each individual tribe and urban Indian health organization. Ms. Schmitz said each tribe is unique with its own culture, language, government, infrastructure, access to health care, laws, geography, and economy. She said what they have in common are shared values of respect and value for their elders; caring for one another; believing that every person has a role; being generous; and not wasting resources.

Ms. Schmitz said the COVID-19 age-adjusted mortality rate for AI/AN people is 2.43 times that of non-Hispanic whites. She said during the H1N1 emergency in 2009–2010, there was an absence of planning for the distribution of medical countermeasures (MCM) (pharmaceuticals, medical treatments, prophylaxes, supplies, equipment, and other items needed to treat or protect against public health threats). Ms. Schmitz said there was no planning or guidance at the state and federal levels regarding distribution of MCM (including vaccines) to tribal nations prior to 2009 and that Washington state’s strategy was to distribute tribes’ vaccine allocations to local health jurisdictions so they would transfer the vaccines to tribes. She said when the Centers for Disease Control and Prevention’s (CDC’s) recommended priority groups (pregnant women, household contacts and caregivers of children less than six months, health care and emergency medical services personnel, all people six months through 24 years of age, and persons aged 25 through 64 years of age with health conditions associated with higher risk of complications from influenza) differed from that determined by tribal sovereignty (some tribes prioritized elders first), there was a catastrophic failure in effective distribution. Ms. Schmitz said certain local health jurisdictions (LHJs) did not understand their lack of authority over tribes and refused to hand over tribes’ vaccine allocations if those tribes’ priority populations differed from CDC recommendations. As a result, some tribes never received their vaccine allocations, and many tribal members died. She said Washington tribes committed to preventing this from happening again.

Ms. Schmitz said Washington implemented cross-jurisdictional collaboration starting with regional cross-jurisdictional planning meetings that included tribes. LHJs and the U.S. Department of Health and Human Services (HHS). That was driven by a mutual aid agreement (MAA) for tribes and LHJs in Washington state, which led to the development of state policy that clearly outlined tribes’ sovereign authority over medical countermeasures and provided advocacy for federal policy. She said up to 75 people collaborated to put together an operational guide to be used by all partners who are ready to respond at a moment’s notice or to ask for help at 3:00 a.m. whenever necessary. Ms. Schmitz said this group did tabletop exercises in 2014 and 2018, followed by a full-scale exercise in 2019 that included mock distribution of MCMs, proving that the state could
deliver critical MCMs when needed to even the most remote reservations. She said that tribes and UIHPs began meeting weekly with Washington State Department of Health (DOH) COVID-19 vaccine team members and the Indian Health Service’s (IHS) regional COVID-19 vaccine coordinator in September 2020 to prepare to receive, store, manage and administer the COVID-19 vaccine. She also said that the relationships and tribal contacts that had been built by the state over several years allowed the state to be ready to go on the first day the COVID-19 pandemic hit. Ms. Schmitz said their achievements were extraordinary in that tribes and UIHPs were prepared to receive vaccine supply from the first shipment. She said 20 of the 29 tribes and both UIHPs chose to order vaccines through Washington state. She added that the four tribes that do not have a medical clinic are vaccinating their communities by leveraging tribal resources and partnerships. Additionally, 14 tribes have now offered their vaccination capacity to support other states and neighboring counties. She said the state now uses a broad definition of “community”—one that includes non-tribal school district staff and teachers; county-wide home health workers; county-wide elders; and other high-risk individuals. Ms. Schmitz recommended the following to other states as a template for key factors for success: 1) build relationships and partnerships across jurisdictions (federal, state, tribal and local); 2) develop and implement policies at federal, state, tribal and local levels that clearly comply with applicable laws; 3) provide training to agency staff at federal, state, tribal and local levels regarding applicable laws, policies, and procedures; and 4) participate in exercises with partners.

Director Wing-Heier asked if some of the tribal elders were reluctant to get vaccines as they were in Alaska because they had previously been used as guinea pigs to test vaccines during earlier pandemics. Ms. Schmitz said some of this had been seen, but most of the tribal elders were leading the charge to get vaccinated. However, she said there was more hesitation from younger groups, maybe due to the misinformation on social media as it varied by community. She said the solution was to share as much information as they could. For homebound tribal members, Ms. Schmitz said the vaccine was taken to people’s homes because Washington had anticipated this and had acquired funding from foundations to purchase vaccine transport coolers and digital recording equipment. Commissioner Trinidad asked if they were providing vaccines to those under the age 16 or 18. Ms. Schmitz said tribes are following medical recommendations. Commissioner Kreidler asked what type of vaccine is being distributed to tribal members. Ms. Schmitz said all three types (Johnson & Johnson, Moderna and Pfizer) because one tribe had ultra-cold storage equipment, so it was able to do Pfizer. Director Wing-Heier said the latest misinformation she had heard was about the Johnson & Johnson was that it was sub-par, which it is not.

3. **Heard a Presentation on Suggestions for Using the Latest Stimulus Package.**

Colin Baillio (New Mexico Office of Superintendent of Insurance) said the federal American Rescue Plan Act (ARPA) changes the federal Affordable Care Act’s (ACA’s) premium assistance by lowering the percent of income paid for the Benchmark Plan for every level of income as a percent of the federal poverty level (FPL) and adds another layer of 8.5% at the 400+% of FPL that had not existed prior to ARPA. He said that silver loading has caused premium subsidies to rise at a faster pace than the price of Bronze plans and that this dynamic has led to many people being eligible for free Bronze plans. Mr. Baillio said according to the Kaiser Family Foundation (KFF), 4 million uninsured Americans qualify for free Bronze plans under the ACA and that this number will increase significantly under the ARPA. He said this has huge implications for how many Native Americans can qualify for a free plan with no cost sharing. Mr. Baillio said in addition to ACA protections and benefits, Native Americans qualify for year-round enrollment and zero cost sharing under 300% FPL, which applies to all metal levels, including Bronze. He said expanding free Bronze plans to more Native Americans could significantly reduce a major barrier to coverage.

Mr. Baillio said in New Mexico, 10,600 Native Americans qualify for Marketplace subsidies and that about three-fourths of these individuals (7,950 people) qualify for zero cost sharing plans. However, only 571 signed up for coverage with zero cost sharing in 2020, which is just 7% of those who qualify for the benefit. At the same time, he said 88.7% of those who qualify for Medicaid have signed up, so awareness is one barrier, but costs are clearly another major barrier to coverage. Mr. Baillio said the Urban Institute study indicates that ARPA adds roughly 70 points to the FPL at all ages and through most all factors. He said possible strategies to reduce or eliminate premiums for Native Americans who qualify for federal subsidies would be to: 1) build upon the new federal premium assistance to fully subsidize Bronze plans for Native Americans. For example, for a 40-year-old in New Mexico’s rural rating area, at 250% FPL, it would cost $3 per person per month; at 275% FPL, it would cost $43 per person per month; and at 300% FPL, it would cost $88 per person per month. This could be financed through Purchased/Referred Care (PRC) or state funds.; 2) require carriers to use the induced demand factors in risk adjustment and assume only people under 200% FPL will enroll in Silver, which is shown to lower the cost of subsidized Bronze and Gold plans; and 3) prohibit age rating to extend lower cost Bronze plans to more lower income, younger individuals, which is counterintuitive to the results of age rating in the subsidized market because now that subsidies extend above 400% FPL, the downsides are less pronounced.
Director Wing-Heier asked how New Mexico would make it work for older tribal members, those in rural areas and those without broadband. Mr. Baillio said they had lots of work to do and that they have not reached out to enough people yet. However, he said they could use the vaccine rollout model to reach tribal members by transferring those techniques to the outreach project and go door to door. Silvia Yee (Disability Rights Education & Defense Fund—DREDF) asked what percentage of tribal members in New Mexico had disabilities and indicated that Bronze plans may not meet their needs. Mr. Baillio said he does not know how many and agreed that Bronze plans may not meet the needs of those who are disabled. He said federally recognized tribes can choose any plan they want to cover essential health benefits (EHB) at no cost, with some metal levels covering less. However, he said coverage under the Bronze plan is like the coverage under Medicaid. Ms. Duhamel said the Bronze plan would essentially equate to giving 10,000 tribal members in New Mexico Medicaid coverage, but that the state needed to get the word out to all tribes first.

Director Wing-Heier congratulated New Mexico on the recent announcement that the new U.S. Secretary of the Interior is from their state.

4. Discussed Other Matters

Director Wing-Heier announced that NAIC staff support is working with the National Congress of American Indians (NCAI) to schedule a meeting for the Liaison Committee either before or after the virtual All Commissioner Fly-in in May to discuss issues of mutual interest with regard American Indians and Alaska Natives. She said the date and time will be distributed when it has been determined.

Having no further business, the NAIC/American Indian and Alaska Native Liaison Committee adjourned.